# VitalAtlanta

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## NEW CLIENT INFORMATION

*As your informed consent states, this information is confidential. This form may bring up feelings. The more information I have is helpful. Only complete what you are comfortable sharing at this time.*

Date _____

First Name _____Middle_____Last_____

Preferred name _____

Email Address _____Type: Work/Home

Permission to send email: (circle one) Yes / No

Primary phone number_____Type: Home /Mobile /Work

It's okay to leave voice messages at this number: (circle one) Yes / No

It's okay to leave text messages at this number: (circle one) Yes / No

Send appointment reminders? (circle one) Yes / No

Send text appointment reminders? (circle one) Yes / No

Street Address _____

City _____ State_____ Zip Code_____

County of residence _____

Date of birth _____ Age _____

Sex: (circle one) Female / Male / Prefer not to say

Gender identity (add gender identity, pronouns, etc)_____

Relationship Status: (circle) Single / Married / Divorced / Domestic Partnership / Long Term Relationship / Separated / Widowed

Employment status: (circle) Full-time / Part-time / Self-employed / Unemployed / Full-time Student / Part-time Student / Retired / Homemaker

Emergency Contact Person: Contact in case of medical or psychological emergency. (Note: This person would only be contacted with your consent, or during life threatening circumstances.)

First Name _____Last Name_____

Relationship (circle one) Child / Family Member / Legal Guardian / Physician / Parent / Spouse / Other

Address _____

Email address _____Work or Home? _____

It's okay to send this contact email in an emergency (circle one) Yes / No

Main phone _____ Work / Mobile / Home?_____

It's okay to leave this contact voice messages in an emergency (circle one) Yes / No

It's okay to leave this contact text messages in an emergency (circle one) Yes / No

Race/ethnicity (optional)_____

Highest level of education completed_____

If applicable, place of employment_____

Occupation _____

Are you satisfied with your role or work environment? _____

Reason _____

Possible days and time range for appointments

_____

_____

If you were referred, by whom? _____

If not, how did you hear about services? _____

How long in married/committed relationship? _____ Partner's age _____

Partner's occupation _____

Do you have children? _____ If yes, ages and genders _____

_____

**Medical History**

Local physician (name and number) _____

_____

Date of last physical _____

Current physical problems, symptoms or concerns _____

_____

_____

Current prescription medications (name, dosage, purpose) _____

_____

_____

Prescribed by (physician name & number) _____

_____

Current over-the-counter medications, supplements, or vitamins _____

_____

_____

Age and nature of previous or childhood illnesses/physical problems _____

_____

Age and nature of previous loss of consciousness _____

_____

Any previous loss from miscarriage, stillbirth, or after live birth_____

_____

Any reproductive concerns _____

_____

What do you know about your own birth history? _____

_____

_____

Currently in counseling or psychotherapy? Yes _____ No _____

If yes, name of therapist _____

Previous counseling or psychotherapy? Yes _____ No _____

For how long? _____When? _____

Psychotropic Medication prescribed _____

Purpose _____

Previous psychiatric hospitalization (where/when) _____

_____ Length of stay _____

Have any family members been hospitalized for psychiatric purposes? Yes _____ No _____

If yes, who? _____ When? _____ How long? _____

In the event of a mental health emergency, please name the nearest mental health hospital to your primary location that you prefer to go to:

Name_____Phone Number_____

**Family Information**

Parental Status: Living together _____ Separated/Divorced _____ Remarried _____

Who did you reside with as a child? _____

_____

Parent's current age _____ Gender _____If deceased, age and year of death _____

Cause _____

Parent's current age _____ Gender _____If deceased, age and year of death _____

Cause _____

Other significant family members, including ages and genders of siblings:

_____

_____

Highest level of education completed: Parent _____ Parent _____

Parent's most recent &/or primary (if different) occupation _____

Parent's most recent &/or primary (if different) occupation _____

Did either parent struggle with alcohol? Yes _____ No _____ Currently _____ Past _____

Did either parent struggle with drugs?

Yes _____ No _____ Currently _____ Past _____ Recreational _____ Prescription _____

Did either parent struggle with any other kind of addiction (food, sex, etc)? If so, what?

_____

Did any siblings struggle with alcohol? Yes _____ No _____ Currently _____ Past _____

Did either siblings struggle with drugs?

Yes _____ No _____ Currently _____ Past _____ Recreational _____ Prescription _____

Did any siblings struggle with any other kind of addiction (food, sex, etc)? If so, what?

_____

Did any grandparents struggle with alcohol? Yes ____ No _____ Currently _____ Past _____

Did either grandparents struggle with drugs?

Yes _____ No _____ Currently _____ Past _____ Recreational _____ Prescription _____

Did any grandparents struggle with any other kind of addiction (food, sex, etc)? If so, what?

_____

Did any other family members struggle with alcohol? Yes ___ No ___ Currently ___ Past ___

Did any other family members struggle with drugs?

Yes _____ No _____ Currently _____ Past _____ Recreational _____ Prescription _____

Did any other family member struggle with any other kind of addiction(food, sex, etc)? If so, who/what?_____

Any environmental issues (i.e. mold, etc.) or concerns in current or past residences or work?

_____

_____

How do you like to spend your free time? _____

_____

How do you cope with stress? _____

_____

Do you engage in any alternative/complementary care to support your health and well-being?

_____

_____

_____

Briefly describe why you are seeking therapy at this time:

_____

_____

_____

_____

What else might be important for your therapist to know?

_____

_____

_____

Client Checklist

Please complete the following checklist. Check only those items which are TRUE or mostly true for you. (Please circle if applicable for specificity)

_____1. A life transition is causing me stress.

_____2. I have just had a major loss.

_____3. I have feelings of overwhelming panic and/or anxiety.

_____4. I am afraid that I'm losing my mind.

_____5. My mind keeps racing, and it is hard to shut out thoughts.

_____6. I am (or have been) seeing or hearing things that others don't see or hear.

_____7. I have disturbing nightmares.

_____8. I have done things to hurt myself physically (suicide attempts, self-harm, etc.).

_____9. I have serious thoughts of suicide.

_____10. My future seems hopeless.

_____11. I have intense emotions.

_____12. My appetite is not like it used to be.

_____13. I have recently lost/gained a significant amount of weight.

_____14. I have sometimes vomited, fasted, or used laxatives or vigorous exercise in order to control my weight.

_____15. A care provider has discussed my weight or size with me.

_____16. I have had intense feelings about gaining weight.

_____17. I have felt fat even though others have said I was thin.

_____18. I have had recurring periods of binge eating (rapid consumption of a large amount of food in a short amount of time).

_____19. I used to sleep normally (e.g. 7-8 hours) every night but now I sleep too much/too little.

_____20. I am concerned about issues of sexuality.

_____21. I experience negative emotions about touch.

_____22. I have sometimes felt like I ought to cut down on my drinking/drug use.

_____23. I have sometimes felt bad or guilty about my drinking/drug use.

_____24. People have sometimes annoyed me by criticizing my drinking/drug use.

_____25. I have sometimes had a drink first thing in the morning to steady my nerves or get rid of my hangover.

_____26. I have experienced traumatic medical procedures

_____27. I have had a sudden inability to recall important personal information (more than ordinary forgetfulness, not due to head trauma, stroke, seizure, or alcohol-related blackouts).

_____28. I have (past or present) experienced sudden unexpected travel away from my home or work place with the inability to recall my past (not due to head trauma, stroke, seizure, or alcohol-related blackouts).

_____29. I have (past or present) assumed a new identity, partial or complete (not due to head trauma, stroke, seizure, or alcohol-related blackouts).

_____30. I have had a persistent or recurrent experience of feeling detached from reality, as if I were an outside observer of my mental processes or body.

_____31. I have (past or present) had a persistent or recurrent experience of feeling like an automaton or as if in a daydream.

_____32. I have felt like there were two or more very different personalities within myself, each of which is dominant at a particular time.

_____33. I feel I have some gaps in my memory after the age of five.

_____34. As a child or adolescent, I experienced bullying from siblings, peers, or others.

_____35. When I was a child or adolescent, an adult overly criticized me, focused on my failures, belittled, and/or swore at me.

_____36. When I was a child or adolescent, an adult punched, bit, kicked, burned, or beat me.

_____37. When I was a child or adolescent, someone fondled me, exposed themselves to me such that I felt frightened, exploited me sexually, and/or attempted sexual contact when I did not want to participate.

_____ 38. When I was a child or adolescent, I felt ignored or as if I didn't exist.

_____39. As an adult, someone overly criticized me, focused on my failures, belittled, and/or swore at me.

_____40. As an adult, someone punched, bit, kicked, burned, or beat me.

_____41. As an adult, someone fondled me, exposed themselves to me such that I felt frightened, exploited me sexually, and/or attempted sexual contact when I did not want to participate.

_____42. I have recently been sexually assaulted.

Does something else come to mind?

_____

_____

What is most important to address in therapy first?

_____

_____

_____