The ANXIETY & STRESS MANAGEMENT INSTITUTE
1640 Powers Ferry Road, Building 9, Suite 100, Atlanta, Georgia 30067, 770.953.0080, www.StressMgt.net

Client Information Form

(Revised July 2013)

This Form is Completely Confidential

Today's date: _____

Your name: _____
Last First Middle Initial

Date of birth: _____ **Gender:** _____ **Social Security #:** _____

Home street address: _____

City: _____ **State:** _____ **Zip:** _____

Name of Employer: _____

Address of Employer: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____
Cell Phone: _____ **Email:** _____

Calls will be discreet, but please indicate any restrictions: _____

_____

Referred by: _____

- May I have your permission to thank this person for the referral? ☐ **Yes** ☐ **No**
- If referred by another clinician, would you like us to communicate? ☐ **Yes** ☐ **No**

Person(s) to notify in case of any emergency: _____
Name Phone

- We will only contact this person if we believe it is a life or death emergency. Please provide your signature to indicate that we may do so. (Your Signature): _____

Please briefly describe your presenting concern(s): _____
_____
_____
_____
_____
_____

What are your goals for therapy? _____
_____
_____
_____
_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

The following information on this form will help guide your treatment.
Please try to fill out as much as you are comfortable disclosing.

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____
_____
_____

Current Medications (if you need more room, please write on the back of this page**:**

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke/use tobacco? ☐ **Yes** ☐ **No** If YES, how much per day? _____
Do you consume caffeine? ☐ **Yes** ☐ **No** If YES, how much per day? _____
Do you drink alcohol? ☐ **Yes** ☐ **No** If YES, how often? _____
Do you use non-prescription drugs? ☐ **Yes** ☐ **No** If YES, what and how often? _____
_____

Have your friends or family members voiced concern about your substance use? ☐ **Yes** ☐ **No**
Have you ever been in trouble/in risky situations because of your substance use? ☐ **Yes** ☐ **No**
Previous medical hospitalizations (Approximate dates and reasons):_____
_____

Previous psychiatric hospitalizations (Approximate dates and reasons):_____
_____

Have you ever talked with a psychiatrist, psychologist, or mental health professional? ☐ **Yes** ☐ **No**
(Please list approximate dates and reasons): _____
_____
_____

Height:_____ Weight (if applicable):_____

SEXUAL & GENDER IDENTITY:
Heterosexual__ Asexual __ Bisexual__ Lesbian__ Gay__ Transgender__ In Question __

RACIAL/ETHNIC IDENTITY:
__ African/African-American/Black
__ American Indian/Alaska Native
__ Asian/Asian-American/Asian Pacific Islander
__ Bi-Racial/Multi-Racial
__ Latino/Latino-American
__ Middle Eastern/Middle Eastern American
__ White/European-American
__ If Not Listed: _____

FAMILY:

How would you describe your relationship with your mother?_____
_____
_____

How would you describe your relationship with your father?_____
_____
_____

Are your parents still married?_____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____
_____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____

_____

How many sisters do you have? _____ Ages? _____
How many brothers do you have? _____ Ages? _____
How would you describe your relationships with your siblings?_____

_____

RELATIONSHIPS, SOCIAL SUPPORT & SELF-CARE:

Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Married/Life Partnered? _____ How Long? ____ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships_____

Do you have Children?____ If YES, how many and what are their ages:_____

Describe any problems any of your children are having: _____

_____

List the names and ages of those living in your household: _____

_____

Please briefly describe any history of abuse, neglect and/or trauma: _____

_____

_____

Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

Please briefly describe your coping mechanisms and self-care:_____

_____

_____

Is spirituality important in your life? If so, please explain: _____

_____

Briefly describe your diet and exercise patterns:_____

_____

EDUCATION & CAREER:

High School/GED___ College Degree___ Graduate Degree(or Higher)___ Vocational Degree___

Are you currently employed? _____ If so, what do you do? _____

_____

Employment Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Any past career positions that you feel are relevant? _____

_____

What do you think are your strengths?_____

_____

_____

_____

PLEASE **CHECK** ALL THAT APPLY & **CIRCLE** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			People in General →			Nausea →		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Concerns			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Hurting Self			Fidget Frequently		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems		Physical Abuse		Depression			
Legal Trouble		Sexual Abuse		Anxiety			
Domestic Violence		Hyperactivity		Psychiatric Hospitalization			
Suicide		Learning Disabilities		"Nervous Breakdown"			

Any additional information you would like to include:

_____

_____

_____

_____