



211 Perimeter Center Parkway, NE Suite 910 Atlanta, Georgia 30346  
Phone: 770-350-3500 Fax: 770-350-3510

**Adult Information Form**

Today's Date: \_\_\_\_\_

Full Name \_\_\_\_\_ Name You Prefer \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

Mailing Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Okay to leave message? Yes / No

Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Okay to leave message? Yes / No

Alternative Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Okay to leave message? Yes / No

Emergency Contact \_\_\_\_\_ Relationship to You \_\_\_\_\_

Address \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Relationship Status: \_\_\_\_\_ Single \_\_\_\_\_ Committed Rel. \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed

Education \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Referred by: \_\_\_\_\_

Service you are requesting: \_\_\_\_\_ Individual Therapy \_\_\_\_\_ Couples Therapy \_\_\_\_\_ Family Therapy

Please list everyone living in your household and their relationship to you:

<u>Name</u>	<u>Age</u>	<u>Gender</u>	<u>Relationship to You</u>
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Please briefly describe concerns or problems that bring you to therapy at this time:

Please circle any of the following areas of concern, either past or present:

Alcohol/Drug Abuse	Hopelessness	Paranoia	Anger Control
Homicidal Thoughts	Parenting Concerns	Anxiety	Hostility
Phobias	Assertiveness	Isolation	School Problems
Attention/Concentration	Impulse Control Problems	Bereavement/Grief	Self-Defeating Behaviors
Insomnia	Self-Esteem Issues	Communication	Excessive Irritability
Self-Injurious Behaviors	Depression	Identity Issues	Sexual Abuse
Dissociation	Legal Issues	Sexuality	Spirituality
Domestic Violence	Marital /Relationship Problems	Stress	Eating/Food Issues
Medical Concerns	Suicidal Thoughts	Memory	Family Problems
Work Problems	Hallucinations (seeing or hearing things)	Panic Attacks	Excessive Worrying
	Delusions (implausible beliefs)		

Medical Problems: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Have you been in counseling or therapy before?      Yes      No

Date                      Nature of Problem                                      Therapist                                      Benefit from therapy?

Current medications:

Medication                      Dosage                                      Reason for Use                                      Prescribing Physician

Please describe use of alcohol or other substances:

Substance                                      Frequency of Use

Please list anyone in your family who has been in therapy or diagnosed with any type of mental illness:

Relationship to You                      Problem                                      Nature of Treatment, if any

Please provide any other information you would like for me to know: