INSPIRING HEALING AND HOPE COUNSELING AND DEVELOPMENT CENTER, LLC
8332 OFFICE PARK DRIVE, SUITE H, DOUGLASVILLE, GA 30134
404-907-6635

CLIENT INFORMATION

A. IDENTIFICATION

Client Name_____ Sex_____
Date of Birth: _____/_____/_____ Age: ____
Employer/School:_____ SS#:____-____-____
Home Address:_____
City:_____ State:_____ Zip Code:_____
Home phone: (____) _____ Work: (___) _____
Cell: (____) _____
Email:_____
Which numbers/email listed above may we leave a message on? _____
If client is a minor: Names of Parent(s)/Guardian(s): _____
Emergency ContactName andNumber:_____

B. RESPONSIBLE PARTY INFORMATION ☐ Check if the same as client (skip this section)

Guardian Name:_____ Sex: _____ DOB: _____
Relation to Patient: _____ SS#_____-_____-_____
Employer:_____
Address:_____

C. MEDICAL HISTORY

Please list all Physician Names & Numbers:
_____
_____
_____
Medication:_____ Dosage: _____ Reason:_____
Medication: _____ Dosage:_____ Reason:_____

Allergies: _____
List any serious accidents, illnesses, operations or hospitalizations and what year
_____

D. FAMILY OF ORIGIN

Relative	Name	Age	Illness	Education	Occupation	Quality of Relationship
Father						
Mother						
Step-Father						
Step-Mother						

Brother (s)						
Sister (s)						

E. Marital History

Spouse's Name:_____ Years Married: _____

Previous Married? ___ Yes ____ No Reason for Divorce:

_____

_____

F. Symptoms

Physical Health/Symptoms

____Headache ___Vomiting ____Diarrhea____ Dizziness____ Chest Pain____ Shortness of Breath

Function/Activity

___Fatigue ___Little/No Sleep ___ Weight Loss ___ Weight Gain ___ Loss of Interest Pleasure ____Excessive Worry ___Self-Injury ____Substance Abuse/Use _____Academic/Work Inhibition

Other:_____

EmotionalSymptoms

Hopelessness Panic/Anxiety Anger Tearful SuicidalThoughts Indecisive _Fearful

Other:_____

Please check all that apply to you and may be a focus of treatment:

- ☐ Anxiety
- ☐ Depression
- ☐ Relationships and Boundary Issues
- ☐ Lying/Manipulation
- ☐ Academic Problems (Children and Adolescents)
- ☐ Behavioral Problems (Children and Adolescents)
- ☐ Marital Concerns
- ☐ Dealing with Divorce
- ☐ Parenting Concerns
- ☐ Risk of harming yourself or others
- ☐ Anger Issues
- ☐ Developmental Problems
- ☐ Sleep Problems
- ☐ Confidence/Self-Esteem Issues
- ☐ Feeling Isolated From Others
- ☐ Afraid or Suspicious
- ☐ Losing Track of Time
- ☐ Nightmares
- ☐ Intrusive Memories
- ☐ Sexual Issues

- [ ] Stress Management
- [ ] Traumatic Experiences
- [ ] Sexual Abuse
- [ ] Physical Abuse (Including Domestic Violence)
- [ ] Emotional/Mental Abuse
- [ ] Loss of Control
- [ ] Destructive Life Patterns
- [ ] Substance Abuse (Past and/or Present)
- [ ] Family of Origin Issues
- [ ] Career Changes
- [ ] Financial Problems
- [ ] Specific Fears or Panic
- [ ] Memory Problems
- [ ] Other:_____

BRIEF SURVEY

What brings you in to therapy today?

Where did you hear about Inspiring Healing and Hope Counseling and Development Center?

What are you hoping for in your therapy experience?

What are your concerns about therapy?

Have you ever been in therapy before?

If yes, was your experience positive or negative and why?

Client or Legal Guardian Signature Date