CAPS-Atlanta

2255 Cumberland Pkwy, 600-150
Atlanta, Georgia 30339
Phone: 404.419.7895 Fax: 404.419.7891
E-Mail: capsatlanta15@gmail.com
Web: www.capsatlanta.com

CLIENT INFORMATION

Name _____ Date _____

Date of Birth ____/_____/_____ Age _____

If a minor-Custodial Parent(s) Name _____

Relationship to client _____

Address (no P.O. Box) _____
Street Address Apartment #

_____
City State Zip Code

Home Phone _____ Cell Phone _____ Work Phone _____
Leave message? ☐Yes ☐No Leave message? ☐Yes ☐No Leave message? ☐Yes ☐No

Email address _____ Reminders via email? ☐Yes ☐No

Occupation (client) _____ Employer/School _____

Grade (if adult, highest grade completed) _____

Financially responsible party

Name _____

Address _____
Street Address Apt # City State Zip

SSN _____ Date of Birth ____/_____/_____

Family and household members (include non-custodial parent, spouse, partner, all children (Continue on back if needed)

Name	Age	Gender	Relationship to client	Living with you?
_____	_____	_____	_____	☐Yes ☐No
_____	_____	_____	_____	☐Yes ☐No
_____	_____	_____	_____	☐Yes ☐No
_____	_____	_____	_____	☐Yes ☐No
_____	_____	_____	_____	☐Yes ☐No

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CLIENT INFORMATION

Briefly describe the current problems or concerns _____

_____

_____

Are you a returning client? ☐Yes ☐No

If not, how did you hear about CAPS-Atlanta? _____

Have you (or the client) ever participated in counseling or psychiatric services? ☐Yes ☐No

Name of previous therapist/agency — Dates of service

_____ _____ - _____

_____ _____ - _____

_____ _____ - _____

Physician's name _____ Phone _____

Current medications	Purpose	Dosage	Length of use
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Emergency Contact's Name _____ Relationship to client _____

Address _____
Street Address Apt # City State Zip

Phone _____

I attest the information provided is true to the best of my knowledge and my signature affirms this

_____ _____
Signature (Legal Guardian if minor) Date

_____ _____
Witness Signature Date