New Beginnings Behavioral Counseling, LLC
9456 South Main Street Suite E-2
Jonesboro, Georgia 30236
(229)726-6130 (Cell)
(678) 759-8029 (fax)

CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _______________

Your name: ____

Last First Middle Initial

Date of birth: ____________________ Social Security #: _____________________________

Home street address: ____

City: ____ State: _______Zip:__________________

Home Phone: _________________________

Name of Employer:____

Address of Employer: ____

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 for us to communicate with one another?

Yes No

Insurance Information (if applicable)

Policyholder’s Name: ____

Policyholder’s SSN: ______-_____-_________ Policyholder’s DOB: ___/___/___

Relationship to Client: ____________________

Primary Insurance Carrier: ____

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Secondary Insurance Carrier: ____

Phone #:______________________________

Member #:_________________________ Group #: _______________________

Person(s) to notify in case of any emergency: ______________________________________

Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I 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)? ___________________________

MEDICAL HISTORY:

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

____

____

Current Medications:

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

Name of Medication	Dosage	Purpose	Prescribing Doctor

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Previous medical hospitalizations (Approximate dates and reasons):

____

____

____

Previous psychiatric hospitalizations (Approximate dates and reasons):

____

____

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? (If yes, please

list approximate dates and reasons):

____

____

____

Height _________ Weight (if applicable) _________ Age_________ Gender _________

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual __Transgender

__ Asexual __ In Question __Other

Racial/Ethnic Identity:

__African/African-American/Black __ Latino/Latino-American __Bi-Racial/Multi-Racial

__American Indian/Alaska Native __ Middle Eastern/Middle Eastern-American

__Asian/Asian-American/Asian Pacific Islander __White/European-American __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? _________________________

____

SOCIAL SUPPORT, SELF-CARE, & EDUCATION: POOR----- EXCELLENT

Child's current level of satisfaction with friends and social support: 1 2 3 4 5 6 7

How would you describe your child's relationships with his/her peers?

____

____

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

____

____

____

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Please briefly describe your child's self-care and coping skills:

____

____

____

What are your child's diet, weight, and exercise/activity patterns?

____

____

____

Please briefly describe your child's school performance and experience:

____

____

What are your child's hobbies, talents, and 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		

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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”	