Renewed Journey Counseling Services, LLC
1479 Brockett Road Suite 101 Tucker, GA 30084
O: (404) 625-5427 F: (404) 508-8944
www.renewedjourney.org

Client Information Form

Today's date: _____

Your name: _____
Last **First** **Middle Initial**

Birthdate: _____ **Insurance Name:** _____ Do you have a Second Insurance: Y / N If Yes, Insurance Name: _____ Insured ID: _____

Home street address: _____

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

Name of Employer/School: _____

Address of Employer/School: _____

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 for us to communicate with one another?
  ☐ **Yes** ☐ **No**

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:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Current PCP: _____ **Previous Psychiatrist:** _____
Have you ever been denied a prescription by a doctor? Yes No If so, why? _____
_____

Do you smoke or 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 much per day/week/month/year? _____
Do you use any non-prescription drugs? (Please remember that this form is completely confidential).
YES NO If YES, what kinds and how often? _____
_____

Do you depend on anything to help cope/manage your life? YES NO If YES, what?
_____
_____

Previous Hospitalizations: (Approximate dates and reasons): _____
_____
_____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____
_____

FAMILY:

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

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

Are your parents still married or did they divorce? _____ 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? _____
_____
_____

RELATIONSHIP STATUS:

POOR EXCELLENT
Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: 1 2 3 4 5 6 7
Married/Life Partnered? _____ How Long? _____ Previously Married/Life Partnered? YES NO
Total Marriages: _____ Total Divorces: _____ Sexual Partner Preference: Male Female Both
Total Pregnancies: _____ Total Births: _____ Miscarriages: _____ Abortions: _____
Total children living with you? ____ If so, what are their ages: _____
Describe any problems any of your children are having: _____

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 Problems			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:

_____

_____

_____

_____