For Office Use Only

Fee:

Therapist Name:

Metropolitan Counseling Services
1900 Century Place, Suite 200
Atlanta, Georgia 30345
(404) 321-1794

NEW CLIENT INFORMATION

Name ____ Date ________________

Primary phone number ____

Other phone number(s) ____

Email address ____

Address ____

____

County of residence ____

Date of birth ________________________ Height ______________ Weight ______________

Race/ethnicity ____

Highest level of education ____

Place of employment ____

Occupation ____

Who referred you to MCS? __________________________ May we contact your referral? _______

Relationship Status (check one):

Single ______ Married/Committed Relationship _______ Widowed _______ Divorced/Separated ______

How long in married/committed relationship? _______________ Partner's age _________________

Partner's business or position ____

Do you have children? ________ If yes, ages and genders ______________________________

Medical History

Local physician (name and number) ____

____

Date of last physical ____

Current physical problems, symptoms or concerns ___________________________________

Current prescription medications (name & dosage) ____

____

Prescribed by (physician name & number) ____

Date and nature of previous significant physical problems ____

____

Currently in counseling or psychotherapy? Yes _________ No _________

If yes, name of therapist ____

Previous counseling or psychotherapy? Yes _________ No _________

For how long? _________________________________When? _________________________________

Medication prescribed ____

Previous psychiatric hospitalization (where/when) ____

____ Length of stay ________________

Have any family members been hospitalized for psychiatric purposes? Yes _________ No _________

If yes, who? __________________________ When? _______________ How long? ________________

<u>Family Information</u>

Parental Status: Living together ________ Separated/Divorced ________

Father's age ____________ If deceased, age and year of death _____________________________

Mother's age ___________ If deceased, age and year of death _____________________________

Highest educational level attained by: Father ___________________ Mother _____________________

Father's most recent business or position ____

Mother's most recent business or position ____

<u>Ages</u> and <u>Genders</u> of siblings: ____

Are/were either of your parents alcoholic or drug addicted? Yes ______ No ______

Are/were any of your siblings alcoholic or drug addicted? Yes ______ No ______

Are/were any of your grandparents alcoholic or drug addicted? Yes ______ No _____

Are/were any other family members alcoholic or drug addicted? Yes ______ No ______

Contact in case of medical or psychological emergency: **(Note:** *This person would only be contacted upon your consent, or upon life threatening circumstances.)*

Name ____ Relationship ________________________

Address ____

Main phone ____________________________ Other phone _______________________________

Briefly describe why you are seeking therapy at this time:

____

____

____

What else might be important for your therapist to know?

____

____

____

____

MCS OFFERS A SLIDING FEE SCALE BASED ON HOUSEHOLD INCOME AND NUMBER OF DEPENDENTS. PLEASE WRITE YOUR TOTAL ANNUAL HOUSEHOLD INCOME BELOW:

____