

Fee:

Therapist Name:

**Metropolitan Counseling Services  
2801 Buford Hwy, Suite 470  
Atlanta, Georgia 30329  
(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? \_\_\_\_\_

**Family Information**

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 \_\_\_\_\_

Ages and Genders 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:

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What else might be important for your therapist to know?

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

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