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NEW CLIENT INFORMATION

Last Name of Client _____ First Name _____ Middle Initial _____

Social Security Number of Client _____

Gender: M or F

Birthdate of Client _____ Email _____

Address - _____

M- Married S- Single S- Separated D - Divorced W - Widowed O - Other

Client Address- _____

Home Telephone _____ Acceptable to leave a message?

YES or NO

Work Telephone _____ Acceptable to leave a message?

YES or NO

Cell Telephone _____ Acceptable to leave a message?

Employer or School Name & Address

Who referred you? _____ Name of an emergency contact _____

Emergency contact phone number _____

Acceptable to leave a message? YES or NO

Personal History Date: _____

Name _____

Email _____ Age _____

Date of birth _____ Gender _____ Female _____

Cell phone _____ Work phone _____

Home phone _____

Is it okay to text or email you regarding appointment scheduling? Yes No

List members of your household and indicate whether they are roommates or family members:

History of legal problems:

How did you learn of my services? _____

Therapy Presenting problem: History of problem: Satisfaction with life:

Describe any attempts/thoughts to harm yourself or others:

Previous therapy experiences:

Goals you may have for therapy: Education/Occupation Education completed:

Current area of study:

Current employer: Work satisfaction: Activities and interests:

Family History Relationship status: _____

Total years together: _____ Years married: _____ Partner's name:
_____ Age: _____

Partner's occupation: _____

Previous marriages or significant relationships: Satisfaction with current relationship:

History of relationship trauma: If you have children, list names and ages: Mother's
name: _____ Age: _____

Describe your mother and your relationship with her:

Frequency and form of communication: _____ Age: _____

Describe your father and your relationship with him:

Frequency and form of communication:

Siblings (names, ages, and significant information): Childhood difficulties or traumas:
Provide any additional information or concerns that you would like for me to know:

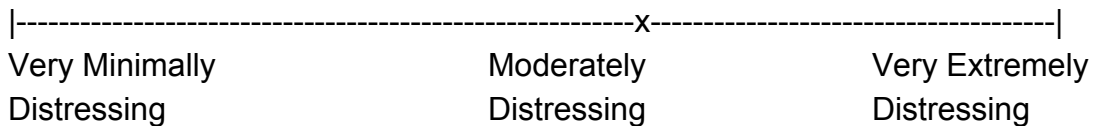
List current medications (including psychotropic and side effects):

List any allergies: _____

Check any of the following symptoms or problems that you currently are or recently have experienced:

List 1	List 2	List 3
<input type="checkbox"/> Parenting Problems	<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Fatigue/Lack of Energy
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Sexual Problems
<input type="checkbox"/> Panic	<input type="checkbox"/> Gender Identity Issues	<input type="checkbox"/> Work Stress
<input type="checkbox"/> Depression	<input type="checkbox"/> Obsessive Thoughts	<input type="checkbox"/> Bad Dreams/Unwanted Memories
<input type="checkbox"/> Loss of Appetite/Over Eating	<input type="checkbox"/> Impulsive Behavior/ Controlled by Others	<input type="checkbox"/> Seeing Things & or Hearing Things
<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Financial Problems	<input type="checkbox"/> Eating Problems
<input type="checkbox"/> Recent Death/Grief	<input type="checkbox"/> Legal Problems	<input type="checkbox"/> Alcohol/Drug Use
<input type="checkbox"/> Marital Problems	<input type="checkbox"/> Spiritual Problems	<input type="checkbox"/> Other

Please use an “X” on the scale below to indicate how distressing your problem(s) are to you.



- Are you currently experiencing any suicidal thoughts? Yes No
- Have you experienced suicidal thoughts in the past? Yes No
- Have you attempted suicide in the past? Yes No
- Are currently experiencing any violent or homicidal thoughts? Yes No

What do you hope to gain from this counseling experience?

Discussed in previous paragraph _____

Identify use of the following:

	Past	Present		Past	Present
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	Marijuana	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	Cocaine	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/> _____

If you use presently, please describe the frequency and amount of use for each substance: _____ I drink one drink every once in a while (about once a month) _____ Have you taken prescription painkillers/sedatives other than as prescribed? Yes No If yes, please explain: _____