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[WWW.HEALGROWEMPOWER.COM](http://WWW.HEALGROWEMPOWER.COM)

Heal. Grow. Empower. .... Healing Families. Growing Relationships. Empowering Individuals.

## Confidential Client Information

Name: \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth/Age \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Social Security Number \_\_\_\_\_

Policyholder Name: \_\_\_\_\_ Home Telephone # \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Policy/Group #/ \_\_\_\_\_ Cell/Work Telephone # \_\_\_\_\_

Policyholder DOB: \_\_\_\_\_ Policyholder SS#: \_\_\_\_\_ Email Address \_\_\_\_\_

Phone Number to Verify Benefits: \_\_\_\_\_

Address to Mail Claims: \_\_\_\_\_

Employer's Name and Address: \_\_\_\_\_

Current Marital Status: \_\_\_\_\_ Date Married: \_\_\_\_\_ Age at Marriage: \_\_\_\_\_

Dates of any previous marriages: \_\_\_\_\_

Name, Age, & Sex of Children (include those of your spouse, those from previous marriages, and any deceased):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Highest Educational Level Attained: \_\_\_\_\_

Current Employment: \_\_\_\_\_

List any major illnesses and injuries you have had in the past: \_\_\_\_\_  
\_\_\_\_\_

List any medications you take: \_\_\_\_\_

List any surgeries or hospitalizations you have had in the past: \_\_\_\_\_

List any allergies to any medications: \_\_\_\_\_

Are you currently under a doctor's care for any physical condition? \_\_\_\_\_

Physical Condition? \_\_\_\_\_

Name and Phone Number of Your Doctor: \_\_\_\_\_

May I contact your Doctor to Coordinate Care if Necessary Yes [ ] No [ ]

If Yes, Please Sign Here for Authorization \_\_\_\_\_

Do you smoke? Yes/No If yes, how many packs per day? \_\_\_\_\_

Do you drink alcohol? Yes/No If yes, how many glasses per day? \_\_\_\_\_

Do you use other drugs Yes/No If yes, What? How frequent? \_\_\_\_\_

Previous counseling or therapeutic help: \_\_\_\_\_

From whom? \_\_\_\_\_ Dates: \_\_\_\_\_

Was counseling beneficial? \_\_\_\_\_ Why or Why not? \_\_\_\_\_

Briefly state why you are seeking therapy and your goals for therapy: \_\_\_\_\_

How long has this situation been in existence? \_\_\_\_\_

Please circle all of the following that apply:

- |                            |                        |                        |                   |
|----------------------------|------------------------|------------------------|-------------------|
| Abuse/Neglect              | Family Conflict        | Panic                  | Stress            |
| Anger                      | Financial Difficulties | Parenting Difficulties | Suicidal Thoughts |
| Anxiety/Nervousness/Fears  | Health Problems        | Promiscuity            | Tiredness         |
| Career/Work Difficulties   | Irritability           | Psychosis              | Trauma History    |
| Concentration Difficulties | Legal History          | Poor Self Control      | Weight Loss/Gain  |
| Depression                 | Loneliness             | Relationship Issues    | Drugs/Alcohol     |
| Divorce/Separation         | Low Self Esteem        | Sexual Problems/Issues | Shyness           |
| Eating Disorder/Problems   | Memory Difficulty      | Social Skills Deficits | Sleep Difficulty  |
| Nightmares                 | Domestic Violence      |                        |                   |
| Others Issues:             | _____                  | _____                  | _____             |

Referred by: \_\_\_\_\_

May we send this person/agency a letter thanking them for their referral to our agency?       Yes    No

May we send you information about our upcoming activities and events by mail or email?       Yes    No

We make reminder calls on the day before appointments. Would you like to receive a reminder of your appointment to your    Home Phone    Cell Phone    Email ?

In case of emergency, contact: \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_