Elizabeth Mehlman Ph.D., J.D.
Licensed Clinical Psychologist
317 Beverly RD. NE. Atlanta, GA 30309
(404) 771-6644

New Client Information Form

Date:_____

Full Name _____ Name You Prefer _____

Date of Birth_____ Age_____ Email _____

Address _____

Check Preferred Phone

☐ **Home (_____)_____ Okay to leave message? Yes / No**

☐ **Work (_____)_____ Okay to leave message? Yes / No**

☐ **Cell (_____)_____ Okay to leave message? Yes / No**

Emergency Contact _____ Relationship to You _____

Address_____

Phone (_____)_____

Relationship Status: ____Single _____ Committed Rel. ____ Married _____ Separated _____Divorced ____ Widowed

Education _____ Occupation _____

Employer_____

Referred by: _____ May I thank them? ____ yes ____no

Service you are requesting: _____Individual Therapy _____Couples Therapy _____Family Therapy

Please list everyone living in your household and their relationship to you:

Name	**Age**	**Gender**	**Relationship to You**

Please briefly describe concerns or problems that bring you to therapy at this time:

Please circle any of the following areas of concern, either past or present:

Alcohol/Drug Abuse	Hopelessness	Paranoia	Anger Control
Obsessive Thoughts	Parenting Concerns	Anxiety	Hostility
Phobias	Assertiveness	Isolation	School Problems
Attention/Concentration	Impulse Control Problems	Bereavement/Grief	Self-Defeating Behaviors
Insomnia	Self-Esteem Issues	Communication	Excessive Irritability
Self-Injurious Behaviors	Depression	Identity Issues	Sexual Abuse
Dissociation	Legal Issues	Sexuality	Spirituality
Domestic Violence	Marital /Relationship Problems	Stress	Eating/Food Issues
Medical Concerns	Suicidal Thoughts	Memory	Family Problems
Work Problems	Hallucinations (seeing or hearing things)	Panic Attacks	Excessive Worrying
Sexual Concerns	Delusions (implausible beliefs)		

Other Concerns: _____

Medical Problems: _____

Primary Physician: _____ Date of Last Visit:_____

Have you been in counseling or therapy before? Yes No

Date	**Nature of Problem**	**Therapist**	**Benefit from therapy?**

Current medications:

Medication	**Dosage**	**Reason for Use**	**Prescribing Physician**

Please describe use of alcohol or other substances:

Substance	**Frequency of Use**

Please list anyone in your family who has been in therapy or diagnosed with any type of mental illness:

Relationship to You	**Problem**	**Nature of Treatment, if any**

Is there anything else you would like me to know?

_____

Client Signature **Date**