North Gwinnett Counseling Associates, LLC
3455-A Lawrenceville-Suwanee Rd. Suwanee, GA 30024

770-932-2899

Adult Information Form

(Revised December 2008)

This Form is Completely Confidential

Name: ________________________________ **Name Preferred to be called:**______________________

DOB:______________________ **Age:**________ **Gender:**___________________

Are you currently employed?________________Fulltime or part-time?____________________________

What is your occupation?_________________________How long have you worked in this position?____

Relationship Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Living together as a couple

If married (or living together): How long in relationship?___________________________

Do you or your spouse/partner have children? If yes, what are their ages?

____

Who resides with you: (Name, relationship, age):

____

____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses):

____

____

____

Current Medications (if you need more room, please write on the back of this page**:**

Doctor: ________________________________ Phone Number: ________________________

Name of medication:	Purpose:	Dosage:	Prescribing Doctor:

Previous medical hospitalizations (Approximate dates and reasons):

____

____

Previous psychiatric hospitalizations (Approximate dates and reasons):

____

____

Have you attended psychotherapy/counseling in the past? ____________

If yes, with whom and for approximately how long?______________________________

Please select symptoms/ situations that apply to you currently or in the past?

( ) Depression
( ) unable to enjoy life
( ) Difficulty concentrating
( ) Anxiety
( ) frequent worry
( ) lack of motivation
( ) Panic Attacks
( ) stress
( ) excessive energy
( ) Problems sleeping
( ) headaches
( ) lack of energy
( ) changes in appetite
( ) Body aches
( ) shakes/ tremors
( ) Anger/ Temper
( ) memory problems
( ) work/school problems
( ) Relationship problems
( ) History of trauma
() History of abuse
( ) Thoughts of wanting to harm self or others
( ) Acts of self harm

How many alcoholic drinks do you consume per week?______________________________

Do you use any other recreational drugs?______ If yes, which ones? ______________________

____

Do you have a history or family history of addiction?______________________________

What would you like to gain from counseling? ______________________________

____