ChangeWorks Atlanta

Client Information Form

Date: ___________________________

Name: ____

Date of birth: ______________ Social Security#: ______________________

Home street address: ____

City: ______________________________ State: ______ Zip:_________

Home Phone: _________________________Work Phone: ____________________

Cell Phone: ____________________________ Email: _________________________

Calls will be discreet, but please indicate any restrictions:
____
____
____

Referred by: ____

If referred by another clinician, would you like for us to communicate with one another?

☐ Yes No ☐

Person(s) to notify in case of any emergency

Name: __________________________________ Phone ___________________

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so:

(Your Signature) ____

Please briefly describe your presenting concern(s):
____
____
____
____

Medical History

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

Current Medications

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

Relationship Status

Currently in Relationship? ☐ Yes No ☐ How Long? _______

Married/Life Partnered? _____ How Long? _____

Previously Married/Life Partnered? ☐ Yes No ☐

If so, length of previous marriages/committed partnerships____________

Do you have children? ☐ Yes No ☐

If YES, how many and what are their ages? ______________________________________

Any additional information you would like to include:

____
____
____
____