Tucker and Associates

Tucker and Associates Psychotherapy and Coaching
1226 Royal Drive Conyers, Ga 30094 ~ 1417 Dutch Valley Place ~Atlanta, GA 30324
770-789-0847

Client History and Information

Name:_____ DOB: ___/___/___ Age: _____

Parent/Legal Guardian (If under the age of 18): _____

Gender: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Address: _____

Primary Telephone Contact:_____Other:_____

Email Address: _____

Emergency Contact: _____ Telephone: _____

Occupation/Employment: _____

Referred by: _____

Have you previously received any type of mental health services (psychotherapy,

psychiatric services, etc.)?
□ No
□ Yes, previous therapists/providers: _____

_____

Have you ever been diagnosed with a psychiatric disorder/condition?

□ Yes □ No

If Yes, please include: _____

Are you currently taking any prescription medication? (Please include any psychiatric medications.)

□ Yes □ No

Please list:

_____

_____

Why are you currently seeking psychotherapy/counseling?

_____

_____

_____

_____

What significant life changes or stressful events have you experienced recently (if any)?

_____

_____

_____

Are you currently experiencing overwhelming sadness, grief, or depression?

□ No □ Yes

If yes, for approximately how long? _____

Are you currently experiencing suicidal ideation or thoughts of hurting yourself or others?

□ No □ Yes

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias?

□ No □ Yes

If yes, when did you begin experiencing this? _____

What changes (if any) would you like to see/make in the following areas:

Family_____

Relationship _____

Friendship_____

Career _____

Health/Fitness _____

Recreational/Leisure_____

Spirituality_____

Education/Learning _____

Do you drink alcohol? If so, how often? □ Daily □ Weekly □ Monthly

If so, how much? _____

Do you currently engage in recreational drug use?

If so, how often? □ Daily □ Weekly □Monthly

If so, how much _____

Do you have a history of Substance and/or Alcohol Abuse or Dependence? If so, please describe with approximate dates / timeframes:

_____

_____

_____

Do you have a history of self-injurious behavior (including cutting and suicide attempts)? If so, please describe with approximate dates / timeframes:

Do you have a history of an eating disorder? If so, please briefly describe with approximate dates / timeframes:

To your knowledge, have you ever experienced any form of physical, emotional, and/or sexual abuse or trauma? If so, please provide a brief history:

In the section below, identify if there is a family history of any of the following.

(If yes, please indicate the family member's relationship to you in the space provided.):

Alcohol/Substance Abuse	

Anxiety	
Depression	
Domestic Violence	
Eating Disorders	
Obesity	
Obsessive Compulsive Behavior	
Mood Disorder	
Schizophrenia	
Suicide Attempt	
Cutting	

Please briefly describe the family you grew up in:_____

_____

_____

_____

Please briefly describe your current family: _____

_____

_____

Please describe your current emotional support system:

_____

_____

_____

Is there anything else you feel like we need to know in order to be most helpful to you?

_____

_____

_____

I hereby certify that the content disclosed within these pages is accurate and complete to the best of my knowledge.

_____

Client Signature Date