For Office Use Only

Fee:

Therapist Name:

Metropolitan Counseling Services
2801 Buford Hwy NE, Suite 470
Atlanta, Georgia 30329
(404) 321-1794

NEW CLIENT INFORMATION

Name ____ Date ____________________

Primary phone number ___________________________________

Other phone number(s) ____

Email address ____

Address: ____

City: ______________________________ State:______________Zip: ________

County of residence (ex. Fulton, DeKalb): ______________________

Date of birth ____________________ Height ___________ Weight ____________

Ethnicity

☐ Not Hispanic or Latino
☐ Hispanic or Latino

Race – *Please Choose One or More*

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

Current Gender Identity ________________

Preferred pronouns ______________

Do you identify as LGBTQ? _____Yes _____No

Highest level of education ____

Place of employment ____

Occupation ____

Metropolitan Counseling Services does not accept insurance of any kind. In an effort to communicate trends in mental health care treatment to the generous donors and foundations who support Metropolitan Counseling Services, please let us know whether you have health insurance coverage by answering the question below:

I do have health insurance: YES NO

Who referred you to MCS? (Please check one)

__Community Service Agency	__Media	__Depression Screening
__In-House Practitioner	__Advertising	__Mental Health Professional
__Physician	__Counseling Center/Agency	__Other Health Professional
__Psychiatric Hospital	__Private Practitioner	__MCS Client
__Internet	__Family/Friend/Coworker	__EAP/Human Resources
__Returning Client	__MCS Literature	
__University Counseling Ctr.	__Religious Organization	

Name of person/agency? ___________________________________May we contact your referral? _____

Relationship Status (check one):

Single ____ Married/Committed Relationship ____ Widowed ____ Divorced/Separated ____

How long in married/committed relationship? _____________ Partner's age ______________

Partner's business or position ____

Do you have children? ____ If yes, ages and genders ________________________________

Medical History

Local physician (name and number) ____

____

Date of last physical ____

Current physical problems, symptoms or concerns ___________________________________

Current prescription medications (name & dosage) ___________________________________

____

Prescribed by (physician name & number) ____

Date and nature of previous significant physical problems ____________________________

____

Currently in counseling or psychotherapy? Yes _________ No _________

If yes, name of therapist ____

Previous counseling or psychotherapy? Yes _________ No _________

For how long? ________________________When? _________________________________

Medication prescribed ____

Previous psychiatric hospitalization (where/when) ___________________________________

____ Length of stay ______________

Have any family members been diagnosed with a psychiatric disorder? Yes ______ No ______

If yes, who? ________________________

Family Information

Parental Status: Living together ________ Separated/Divorced ________

Father's age _______ If deceased, age and year of death ___________________________

Mother's age _______ If deceased, age and year of death ___________________________

Highest educational level attained by: Father _______________ Mother _________________

Father's most recent business or position ____

Mother's most recent business or position ____

Ages and Genders of siblings: ____

Are/were either of your parents alcoholic or drug addicted? Yes ______ No ______

Are/were any of your siblings alcoholic or drug addicted? Yes ______ No ______

Are/were any of your grandparents alcoholic or drug addicted? Yes ______ No _____

Are/were any other family members alcoholic or drug addicted? Yes ______ No ______

Are/were any of family members hospitalized for alcohol or drug addiction? Yes ______ No _______

Contact in case of medical or psychological emergency: **(Note:** *This person would only be contacted upon your consent, or upon life threatening circumstances.)*

Name _______________________________________ Relationship ____________________

Address ____

Main phone ___________________________ Other phone ___________________________

Briefly describe why you are seeking therapy at this time:

____

____

____

What else might be important for your therapist to know?

____

____

____

____

MCS OFFERS A SLIDING FEE SCALE BASED ON HOUSEHOLD INCOME AND NUMBER OF DEPENDENTS. PLEASE WRITE YOUR TOTAL ANNUAL HOUSEHOLD INCOME BELOW (You will be required to offer proof of income by your therapist)

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