5500 Poplar Avenue
Suite 11
Memphis, TN 38119

PROTEA
COUNSELING & CONSULTATION GROUP, PLLC

Adult Client Contact Form

Name _____Age _____ Sex _____ Marital Status _____

Spouse's Name (if applicable) _____Age_____Occupation_____

Date of Birth _____ Social Security Number _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Ethnicity _____ Religious Background _____

Education _____ Place of Employment _____

Work Address _____Work Phone _____

City _____ State _____ Zip _____

Daytime phone number where you wish to be reached regarding appointments: _____

Calls will be discreet, but please indicate any restrictions regarding calls:

_____

_____

Responsible Party (if other than client) _____

Relationship to Client _____Phone Number_____

Who referred you to us? _____ Date problems first noted _____

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Date(s) of any previous therapy/treatment _____

Who provided the previous treatment? _____

Are you currently seeing a psychiatrist, therapist/psychologist/counselor? _____

Have you ever been hospitalized for a mental or emotional illness? _____

Who is your primary care physician? _____

Primary Care Physician's Address _____

When was your last comprehensive medical evaluation? _____

Please list any medications you are currently taking _____

Special Note _____

Closest Relationships: Please list name, age, relationship to you, and whether they live with you.

Name _____Age_____ Relationship to you_____ Living with you_____

Name _____Age_____ Relationship to you_____ Living with you_____

Name _____Age_____ Relationship to you_____ Living with you_____

Name _____Age_____ Relationship to you_____ Living with you_____

Name _____Age_____ Relationship to you_____ Living with you_____

Please describe your current living arrangement.

_____

_____

_____

Has anyone in your family ever been hospitalized for an emotional or mental illness?

_____

_____

_____

Do you or any family members have a history of substance abuse or addiction? Y/N
If yes, please describe. _____

_____

_____

I would describe my relationships with my friends as: Close Somewhat close Distant Conflicted

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I would describe my relationship with my mother as: Close Somewhat Close Distant Conflicted

I would describe my relationship with my father as: Close Somewhat Close Distant Conflicted

Common problem/symptom checklist. Please fill in 0-none, 1-mild, 2-moderate, 3-severe

___Marriage	___Divorce/Separation	___Alcohol/Drugs	___God/Faith
___Pre-marital	___Child Custody	___Other Addictions	___Church/Ministry
___Being single	___Disabled	___Grief/Loss	___Past Hurts
___Sexual Issues	___Work/Career	___Depression	___Codependency
___Family	___School/Learning	___Fear/Anxiety	___Intimacy
___Children	___Money/Budgeting	___Anger Control	___Communication
___Parents	___Aging/Dependency	___Loneliness	___Self-Esteem
___In-laws	___Weight Control	___Mood Swings	___Stress Control

Please tell us in your own words what brings you here today.

_____
_____
_____
_____
_____
_____
_____
_____

What are your 2 most important goals for therapy?

1.

2.

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