Amy Rostand Morris, LCSW, LLC
41 – A Lenox Pointe, NE
Atlanta, Georgia 30324
404 – 654 – 0313

Client Information Sheet

Client's name: _____Date: _____

Address: _____

City, State: _____ Zip: _____

Phone numbers ***with area code*** Home: ( )_____

Work: ( )_____ Cell: ( )_____

Birth date: _____ Age: _____ Social Security Number: _____

Employer: _____

Position: _____For how long?_____

Education: _____

Marital/relationship status: _____ Significant other's name: _____

Significant other's age and sex: _____ How long together? _____

Names and ages of all children in the home: _____

How did you hear about Amy Morris, LCSW, LLC?_____

Who shall we contact in case of emergency?

Name: _____Phone ( )_____

In this box, please indicate the address and telephone number you want me to use to when sending bills or when I need to contact you. If this box is left blank, I will use the address and any of the telephone numbers you have provided above.

If you do *not* want me to leave a message on your answering machine, please tell me how you want me to reach you by phone:

Medical and Health History

Name:_____Date:_____

List any allergies you have: _____ None_____

Primary Care Physician: _____Address:_____

City:_____ State:_____ ZIP:_____

Primary Care Physician's phone number: (_____) _____

Date of your most recent physical examination:_____

Please list all current medications and dosages:

Name of Medication	Dosage	Name of Prescribing Doctor	When did you start taking it?

Please list all current or past health problems, and any major operations:

Current	Past

List all therapists you have seen, and dates you saw them: _____

_____

List any substance abuse treatment or inpatient psychiatric treatment you have had, and the dates:_____

Please indicate which of these substances you currently use:

Substance	Amount used	How often?
Cigarettes		
Alcohol		
Pills not prescribed for me		
Marijuana		
Cocaine or crack		
LSD		
Heroin		
Other (please list):		

What kind of problem brings you to see me?

_____

_____

_____

_____

Please indicate if you are having any of the following problems, or if you had them in the past:

	I have this now	**I had it in the past**
Difficulty falling asleep or staying asleep	_____	_____
Sleeping too much	_____	_____
Change in appetite, weight loss, or weight gain	_____	_____
Frequent crying	_____	_____
Panic attacks or anxiety attacks	_____	_____
Thoughts of killing or hurting myself	_____	_____
Attempts to kill or hurt myself	_____	_____
Problems concentrating	_____	_____
Problems remembering things	_____	_____
Periods of daily sadness lasting more than two weeks	_____	_____
I startle easily	_____	_____
Can't stop remembering upsetting past events	_____	_____
Difficulty controlling my temper	_____	_____
I physically hurt other people	_____	_____
I break things sometimes	_____	_____
I worry a lot	_____	_____
Little or no interest in sex	_____	_____
I feel tired almost every day	_____	_____
Feelings of unreality	_____	_____
Made myself throw up in order to lose weight	_____	_____
Used laxatives or exercised excessively to lose weight	_____	_____
I often feel like I am an outsider	_____	_____
Sexual problems	_____	_____
Worry that something is wrong with my body	_____	_____
Frequent arguments with the people I live with	_____	_____
I hear voices inside my head	_____	

Other (please list):

_____

_____

_____