Natalie Kohlhaas MA LPC NCC CPCS
83 Barnes Street, Senoia Georgia, GA 30276
404-542-3502 IMHCounseling@yahoo.com

Integrative Mental Health Counseling

CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____

Your child's name: _____
Last First Middle Initial

Parent or Legal Guardian's Name: _____
Last First Middle Initial

Child's date of birth: _____ **Gender:** _____

Parent or Legal Guardian's Social Security #: _____

Home street address: _____

City: _____ **State:** _____ **Zip:**_____

Parent or Legal Guardian's Name of Employer: _____

Address of Employer: _____

City: _____ **State:** _____ **Zip:**_____

Home Phone: _____ **Work Phone:** _____
Cell Phone: _____ **Email:** _____
Calls will be discreet, but please indicate any restrictions:_____
_____

Referred by: _____
- May I have your permission to thank this person for the referral?
  ☐ **Yes** ☐ **No**
- 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
We will only contact this person if we believe it is a life or death emergency. Please provide your signature to indicate that we may do so: (Your Signature):_____

Please briefly describe your child's presenting concern(s):_____
_____
_____

What are your/your child's goals for therapy? _____
_____
_____

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How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)?_____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses your child has had:_____
_____
_____
_____

Current Medications (if you need more room, please write on the back of this page):

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons): _____
_____
_____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____
_____

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? (If yes, please list approximate dates and reasons): _____
_____
_____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual
__Transgender __ Asexual __In Question __Other

Racial/Ethnic Identity:
__African/African-American/Black
__American Indian/Alaska Native
__Asian/Asian-American/Asian Pacific Islander
__Bi-Racial/Multi-Racial
__ Latino/Latino-American
__ Middle Eastern/Middle Eastern-American
__White/European-American
__Not listed

FAMILY:

How would you describe your child's relationship with his or her mother?_____
_____
_____

How would you describe your child's relationship with his or her father?_____
_____
_____

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Are the child's parents still married or did they divorce?_____ If they divorced, how old was the child when the parents separated or divorced and how do you think this impacted him or her? _____
_____

Please describe your child's relationship with his or her grandparents: _____
_____
_____

Were there any other primary care givers who have had a significant relationship with your child? If so, please describe how these people may have impacted your child's life: _____
_____
_____

How many sisters does your child have? _____ Ages and Names _____
Names _____

How many brothers does your child have? _____ Ages? And Names _____
Names _____

How would you describe your child's relationships with his or her siblings?_____
_____
_____
_____

Describe any problems any of your children are having:
_____
_____

List the NAMES and ages of other family/nonfamily living in your household:
_____
_____

SOCIAL SUPPORT, SELF-CARE, & EDUCATION:

POOR EXCELLENT

Child's current level of satisfaction with friends and social support: 1 2 3 4 5 6 7

How would you describe your child's relationships with his/her peers? _____
_____

Please briefly describe any history of abuse, neglect and/or trauma: _____
_____
_____

Please briefly describe your child's self-care and coping skills: _____
_____
_____

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What are your child's diet, weight, and exercise/activity patterns?_____
_____
_____

Please briefly describe your child's school performance and experience:_____
_____
_____

What are your child's hobbies, talents, and strengths?_____
_____
_____

What School does the child attend? _____

What Grade is your child currently in? _____ Primary Teacher Name _____

Does your child currently have a 504? _____

Do you have a pet? _____ what type of Pet: _____
Name _____ Age _____ Type _____
Name _____ Age _____ Type _____
Name _____ Age _____ Type _____

Are they close with your pet (s)?
_____

Any additional information you would like to include:

_____
_____
_____

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PLEASE CHECK ALL THAT APPLY TO YOUR CHILD & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST
Anxiety →				Tantrums →				Nausea →		
Depression				Parents Divorced				Stomach Aches		
Mood Changes				Seizures				Fainting		
Anger or Temper				Cries Easily				Dizziness		
Panic				Problems with Friend(s)				Diarrhea		
Fears				Problems in School				Shortness of Breath		
Irritability				Fear of Strangers				Chest Pain		
Concentration				Fighting with Siblings				Lump in the Throat		
Headaches				Issues Re: Divorce				Sweating		
Loss of Memory				Sexually Acting Out				Heart Problems		
Excessive Worry				History of Child Abuse				Muscle Tension		
Wetting the Bed				History of Sexual Abuse				Bruises Easily		
Trusting Others				Domestic Violence				Allergies		
Communicating with Others				Thoughts of Hurting Someone Else				Often Makes Careless Mistakes		
Separation Anxiety				Hurting Self				Fidgets Frequently		
Alcohol/Drugs				Thoughts of Suicide				Impulsive		
Drinks Caffeine				Sleeping Too Much				Waiting His/Her Turn		
Frequent Vomiting				Sleeping Too Little				Completing Tasks		
Eating Problems				Getting to Sleep				Paying Attention		
Severe Weight Gain				Waking Too Early				Easily Distracted by Noises		
Severe Weight Loss				Nightmares				Hyperactivity		
Head Injury				Sleeping Alone				Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems				Physical Abuse				Depression		
Legal Trouble				Sexual Abuse				Anxiety		
Domestic Violence				Hyperactivity				Psychiatric Hospitalization		
Suicide				Learning Disabilities				"Nervous Breakdown"		

Any additional information you would like to include:

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Natalie Kohlhaas MA LPC NCC BCPC

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Integrative Mental Health Counseling LLC

Name_____ Date_____

Cognitions Questionnaire

Below are some thoughts or ideas that may pass through your mind when you are nervous or frightened.

Rate from 1 - 5 using the scale below

1. thought never occurs
2. Thought rarely occurs
3. Thought occurs half of the times I am nervous
4. Thought usually occurs
5. Thought always occurs when I am nervous

___ I am going to throw up
___ I am going to pass out
___ I must have a brain tumor
___ I will have a heart attack
___ I will choke to death
___ I am going to act foolishly
___ I am going blind
___ I will not be able to control myself
___ I will hurt somebody
___ I am going to have a stroke
___ I am going to scream
___ I am going to babble or talk funny
___ I will be paralyzed by fear

Body Sensations Questionnaire

Below is a list of body sensations that may occur when you are nervous or frightened.

Rate from 1 - 5 using the scale below

1. Not frightened or worried by this sensation
2. Somewhat frightened by his sensation
3. Moderately frightened by this sensation
4. Very frightened by this sensation
5. Extremely frightened by this sensation

___ Heart palpitations
___ Pressure or a heavy feeling in chest
___ Numbness in arms or legs
___ Tingling in the fingers/ hands
___ Numbness in another part of your body
___ Feeling short of breath
___ Dizziness
___ Blurred or distorted vision
___ Nausea
___ Having "butterflies" or a "rock" in your stomach
___ Having a lump in your throat
___ Wobbly or rubber legs
___ Sweating
___ a dray throat
___ feeling disoriented and confused
___ feeling disconnected from your body: Only partly present