BALANCED Mind
PSYCHOLOGICAL SERVICES
Dr. Audrey Atkinson
903 Northeast Drive #102, Davidson, NC, 28036
980-221-2113

New Client Form

Client Contact Information

Name_____Preferred Name _____
Last First MI

Address_____

Best contact phone number: _____ Okay to leave a message? YES NO

Emergency Contact Information

(1) Name_____Relationship_____

Address _____

City, State, ZIP _____

Home Telephone # _____ Cell # _____

Work Telephone # _____ Employer _____

(2) Name_____Relationship_____

Address _____

City, State, ZIP _____

Home Telephone # _____ Cell # _____

Work Telephone # _____ Employer _____

Medical Contact Info:

Doctor Name. _____ Phone # _____

☐ I have voluntarily provided the above contact information and authorize Balanced Mind Psychological Services and its representatives to contact any of the above on my behalf in the event of an emergency.

Demographics
Date of Birth: _____/_____/_____ Age: _____

How do you describe your race/ethnicity? _____ What is your gender? _____

How do you describe your sexual orientation? _____

How do you describe your religious or spiritual beliefs? _____

Current relationship status (Circle one):
-Single -Dating, not living together -Cohabiting with partner -Married, living together -Married, not living together -Separated -Widowed -Divorced

On a scale from 1-10 how would you rate your current relationship? _____

List all of the members of your household, and all others living in your home

Name	Age	Relationship (i.e. spouse, child, etc)

Family Background

Where did you grow up? _____

Primarily raised by : ____mother _____father _____grandparents _____step parent
Other: _____

Parents Married ? YES NO If Divorced, when? _____ Age _____

Mother deceased? YES NO If so when? And how?_____
Father deceased? YES NO If so when? And how?_____

Relationship with parents described as _____

How many brothers? _____ Ages _____
How many sisters? _____ Ages _____

Describe relationships with siblings _____

Education History

Highest degree obtained: (List year completed)

-High school graduate _____ -G.E.D. ____ -Associates Degree_____

-4 year college degree_____ -Graduate Degree: _____

Occupational History

What best describes your current employment status? (Please circle one)

-Unemployed, not looking for employment -Unemployed, looking for employment -Full-time employed

-Part-time employed -Retired -Self-employed

What is your occupation? _____

Military History

Have you ever served in the military? YES NO

If Yes, what were your dates of service? _____ Branch of Service _____

Any history of combat? YES NO

Legal History

Do you have any pending legal action or court proceedings? YES NO

Are you currently on probation or parole? YES NO

Any past legal history (arrests, charges, convictions, jail/prison time)? YES NO

If Yes, please explain: _____

_____

Mental Health History

Please briefly state the primary reason for your visit today:

_____

_____

Are you currently receiving mental health care? YES NO

(If yes) Name: _____ Contact Number: _____

Have you ever seen a psychiatrist/psychotherapist before? YES NO

Name: _____ Contact Number: _____

If Yes, when? _____ Did you find your previous treatment to be helpful? YES NO

Have you ever been treated for any of the following (check all that apply):

___ Depression
___ Panic Attacks
___ ADHD
___ PTSD
___ Binge-eating
___ Schizophrenia
___ Alcohol Problems (including AA)
___ Suicidal or self-injurious behavior
___ Problems coping with stress
___ Other _____

___ Anxiety
___ Anorexia/ Bulimia
___ OCD

___ Bipolar (Manic / Depressive) Disorder
___ Personality Disorders
___ Substance Use
___ Relationship difficulties
___ Phobias

Have you ever been hospitalized for psychiatric reasons? YES NO
If yes, please provide details below:

_____

_____

_____

Please list all current medications below:

Name of Medication Dosage

_____

_____

_____

_____

_____

Have you been prescribed psychiatric medication in the past? YES NO

Is there any family history of substance abuse? YES NO If Yes, please describe_____

_____

_____

_____

_____

Is there any family history of mental illness? YES NO If Yes, please describe_____

_____

_____

_____

_____

Referral Information

How did you hear about us?

☐ Website	☐ Psychology Today	☐ Google Search	☐ Brochure or Flyer
☐ Facebook	☐ Therapy Den	☐ Good Therapy	☐ Business Card
☐ BCBS	☐ Healthcare Provider Name_____	☐ Postpartum Support International	☐ Other (please list)_____

If you were referred to us by a healthcare provider, may we send that person a thank-you card for sending you our way? YES NO

_____ _____
Client Signature Date

_____
Printed Name

_____ _____
Audrey Atkinson, Psy.D. Date
Licensed Psychologist