CONFIDENTIAL

Centerpointe of NW GA, LLC
720 S. Glennwood Avenue Suite 102 Dalton GA 30720, 706.225.9434 centerpointenwga@gmail.com

Date:_____ Name:_____

Address:_____

Preferred Phone Number:_____ Date of Birth:_____ Referral Source:_____

Marital Status: [ ] Single [ ] Separated [ ] Divorced [ ] Married

Employer: _____ Occupation:_____

Immediate Family / Household Members

Name: Age: Relationship:

_____

_____

_____

Insurance Information:

Insured's Name: _____

Insurance Company: _____

Insured's ID #: _____ Group #: _____

Insured's DOB: _____ Insured Employer:_____

Emergency Information:

Primary Care Physician: _____ Phone: _____

Name of Emergency Contact: _____ Phone: _____

Briefly describe your reason for contacting a mental health professional today: _____

_____

_____

_____

_____

_____

What do you hope to accomplish by coming here today? _____

_____

_____

_____

_____

_____

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Name: _____ Date: _____

How has this problem affected your:	Does Not Apply	Mild	Moderate	Severe
Marriage/Partner?	[ ]	1	2	3
Family?	[ ]	1	2	3
Job/School Performance?	[ ]	1	2	3
Friendships?	[ ]	1	2	3
Financial Situation?	[ ]	1	2	3
Legal Situation?	[ ]	1	2	3
Health?	[ ]	1	2	3
Anxiety Level / Nerves?	[ ]	1	2	3
Mood?	[ ]	1	2	3
Eating Habits?	[ ]	1	2	3
Sleeping Habits?	[ ]	1	2	3
Ability to Concentrate?	[ ]	1	2	3
Child Rearing?	[ ]	1	2	3
Ability to Control Your Temper?	[ ]	1	2	3

Substance Use:	**Yes**	**No**
Have you ever felt like you should cut down on your alcohol or other drug use (including prescription drugs)?	[ ]	[ ]
Has a friend or relative discussed concerns about your use?	[ ]	[ ]
Have you ever felt guilty about your drinking or drug use?	[ ]	[ ]
Have you ever had to take a drug or use a drug the next day to steady your nerves?	[ ]	[ ]
Are you a recovering alcoholic or recovering drug addict?	[ ]	[ ]
Is there a history of problems with alcohol or drug use in your family?	[ ]	[ ]

Substance Use History

Substance	Amount	Frequency	Duration	First Use	Last Use
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Opioids/Narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Others:					

Current Medications (Include prescribed dosages, dates of initial prescription and refills, and name of doctor prescribing medications): _____

_____

_____

_____

Hospitalizations/Surgeries (include dates, complications, adverse reactions to anesthesia, outcomes, etc.): _____

_____

Any relevant medical conditions (include diabetes, hypertension, head traumas, cardiac problems, asthma or other breathing problems, cancer, etc.): _____

_____

_____

Signature: _____ **Date:** _____