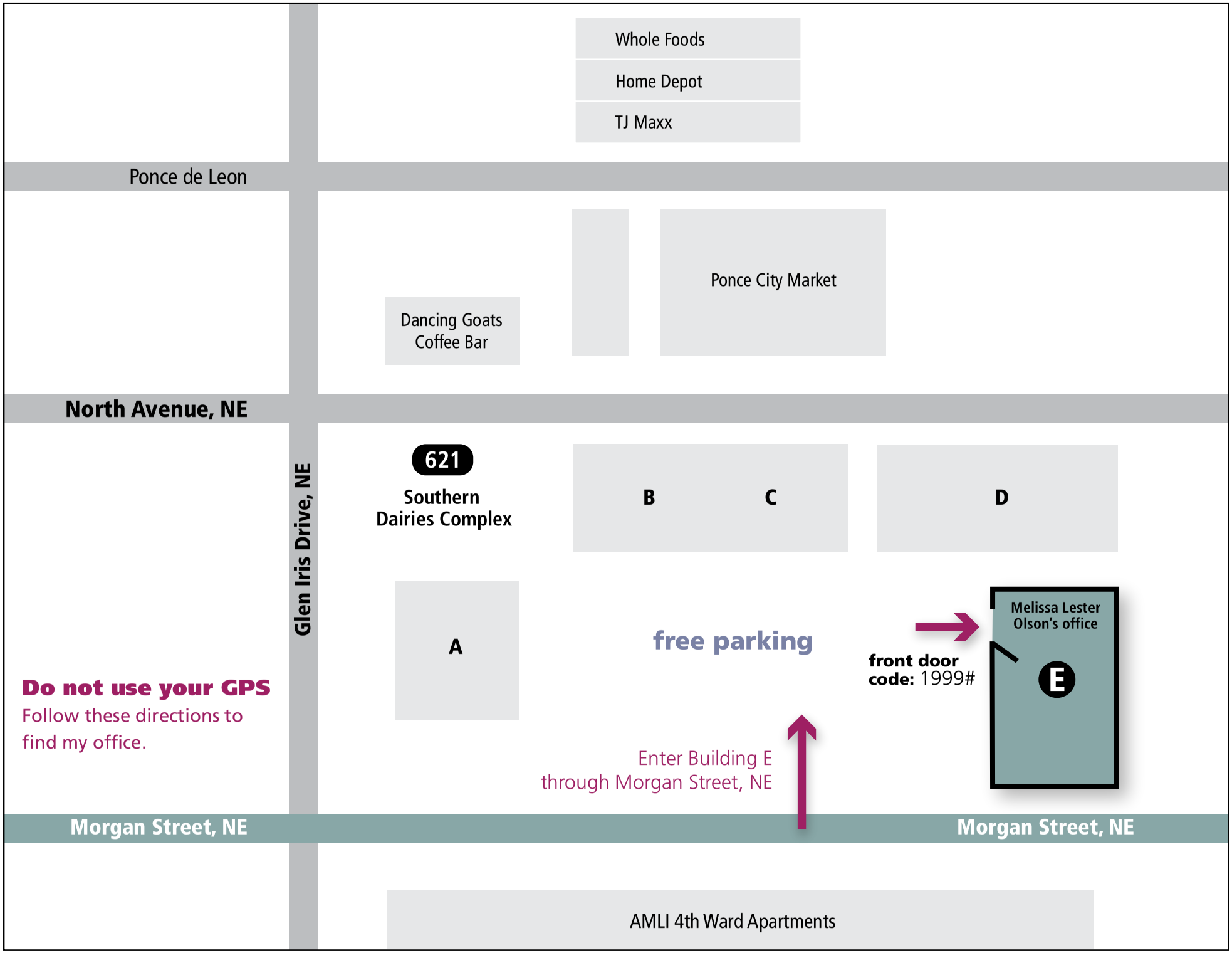
Whole Foods
Home Depot
TJ Maxx
Ponce de Leon
Dancing Goats Coffee Bar
Ponce City Market
North Avenue, NE
Glen Iris Drive, NE
621
Southern Dairies Complex
B
C
D
A
free parking
front door code: 1999#
Melissa Lester Olson's office
E
Do not use your GPS
Follow these directions to find my office.
Enter Building E through Morgan Street, NE
Morgan Street, NE
Morgan Street, NE
AMLI 4th Ward Apartments

MELISSA LESTER OLSON, LCSW
A Women's Therapy and Counseling Practice

621 North Avenue NE
Building E
Atlanta, GA 30308

770 313 7768
Melissa@MelissaLesterOlson.com
www.melissalesterolson.com

Client Biography

Date _____

Name _____ Age _____ Date of Birth _____

Cell phone _____ Email address _____

Mailing Address _____ City _____ State _____ Zip _____

Gender Identification: _____ Sexual Orientation: ○ Bi ○ Lesbian ○ Straight ○ Questioning ○ Other

Marital or Partner Status: _____

Please list names and ages of your children below.

	NAME	AGE
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____

Years of education _____ Occupation _____

Height _____ Weight _____

If you have had bariatric surgery, please provide relevant information. _____

_____

Have you received therapy in the past? ○ Yes ○ No

If yes, please briefly describe. _____

_____

What are your main reasons for seeking therapy now?

List any major illnesses and/or operations you have had?

List any physical concerns you are having at present (high blood pressure, headaches).

When was your most recent complete physical exam? _____

Any abnormal results of physical exam? _____

Medications, Dosages, and Purpose of each:

	MEDICATION	PURPOSE
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____

Present religious affiliation? _____ How important is religious commitment to you? _____

Would you like to have your religious beliefs incorporated into counseling? ○ Yes ○ No

Mother's age _____ If deceased, how old were you when she died? _____

Father's age _____ If deceased, how old were you when he died? _____

If they divorced, how old were you then? _____

Number of brother(s) _____ their ages _____ Number of sister(s) _____ their ages _____

I was child number _____ in a family of _____ children.

Were you adopted or raised with parents other than your natural parents? ○ Yes ○ No

Briefly describe your relationship with your brothers and/or sisters.

_____

_____

_____

Which of the following best describes the family in which you grew up?

Warm and accepting				Average				Hostile and fighting
1	2	3	4	5	6	7	8	9

Which of the following best describes the way in which your family raised you?

Allowed me to be independent				Average				Tried to control me
1	2	3	4	5	6	7	8	9

YOUR MOTHER OR MOTHER FIGURE

Briefly describe your mother. _____

_____

How did she discipline you? _____

_____

How did she reward you? _____

_____

How much time did she spend with you when you were a child? _____

Your mother's occupation when you were a child _____

How did you get along with your mother when you were a child?

How do you get along with your mother now?

Did your mother have any problems (alcoholism, violence, etc.) that may have affected your childhood development?

Is there anything unusual about your relationship with your mother?

YOUR FATHER OR FATHER FIGURE

Briefly describe your father

How did he discipline you?

How did he reward you?

How much time did he spend with you when you were a child? _____

Your father's occupation when you were a child _____

How did you get along with your father when you were a child?

How do you get along with your father now?

Did your father have any problems (alcoholism, violence, etc.) that may have affected your childhood development?

Is there anything unusual about your relationship with your father?

Are there current problems in your family life?

How would you describe your marriage or partnership?

Describe your drinking habits (# of drinks per day/week, what you drink, with whom, etc.).

Drug experience

Drug				
Marijuana	○ Experimented	○ Current Use	○ In the past	○ Don't touch
Cocaine	○ Experimented	○ Current Use	○ In the past	○ Don't touch
Pills	○ Experimented	○ Current Use	○ In the past	○ Don't touch
Heroin	○ Experimented	○ Current Use	○ In the past	○ Don't touch
_____	○ Experimented	○ Current Use	○ In the past	○ Don't touch

Thoughts and Behaviors

Please check how often the following thoughts occur to you.

1)	I want to die.	○ Never	○ Rarely	○ Sometimes	○ Freq
2)	I want to hurt someone.	○ Never	○ Rarely	○ Sometimes	○ Freq
3)	I am going crazy.	○ Never	○ Rarely	○ Sometimes	○ Freq
4)	People hear my thoughts.	○ Never	○ Rarely	○ Sometimes	○ Freq
5)	Someone is watching me.	○ Never	○ Rarely	○ Sometimes	○ Freq
6)	I hear voices in my head.	○ Never	○ Rarely	○ Sometimes	○ Freq
7)	I am out of control.	○ Never	○ Rarely	○ Sometimes	○ Freq
8)	I am so depressed.	○ Never	○ Rarely	○ Sometimes	○ Freq
9)	God is disappointed in me.	○ Never	○ Rarely	○ Sometimes	○ Freq
10)	I can't be forgiven.	○ Never	○ Rarely	○ Sometimes	○ Freq
11)	Life is hopeless.	○ Never	○ Rarely	○ Sometimes	○ Freq
12)	No one cares about me.	○ Never	○ Rarely	○ Sometimes	○ Freq
13)	I am lonely.	○ Never	○ Rarely	○ Sometimes	○ Freq
14)	I am a failure.	○ Never	○ Rarely	○ Sometimes	○ Freq
15)	Most people don't like me.	○ Never	○ Rarely	○ Sometimes	○ Freq
16)	I am so stupid.	○ Never	○ Rarely	○ Sometimes	○ Freq
17)	I can't concentrate.	○ Never	○ Rarely	○ Sometimes	○ Freq
18)	Why am I so different?	○ Never	○ Rarely	○ Sometimes	○ Freq
19)	I can't do anything right.	○ Never	○ Rarely	○ Sometimes	○ Freq
20)	I have no emotions.	○ Never	○ Rarely	○ Sometimes	○ Freq

Please comment on the above thoughts that are an urgent concern to you.

Have you ever been the victim of abuse? _____

Emotional abuse? _____

Physical abuse? _____

Sexual abuse? _____

Other abuse? _____

Have you ever been in legal trouble or in jail? Please describe. _____

_____

Symptoms

Please check the behaviors and symptoms that occur to you more often than you would like.

○ aggression	○ drug use	○ loneliness	○ disorg'd thoughts
○ alcohol use	○ eating disorder	○ memory impairment	○ trembling
○ anger	○ elevated mood	○ mood shifts	○ withdrawing
○ isolating	○ fatigue	○ panic attacks	○ worrying
○ anxiety	○ hallucinations	○ phobias/fears	○ no enjoyment
○ avoiding people	○ heart palpitations	○ recurring thoughts	○ weepiness
○ chest pain	○ high blood pressure	○ sexual difficulties	○ other (specify):
○ depression	○ hopelessness	○ physical illness	_____
○ disorientation	○ impulsivity	○ sleeping problems	_____
○ distractibility	○ irritability	○ speech problems	_____
○ dizziness	○ judgment errors	○ suicidal thoughts	

List your five greatest strengths.

1) _____

2) _____

3) _____

4) _____

5) _____

List five areas in which you would like to grow.

1) _____

2) _____

3) _____

4) _____

5) _____

List your main social difficulties.

_____

_____

_____

List your main love and sex difficulties.

_____

_____

_____

List your main difficulties at school or work.

_____

_____

_____

List your main difficulties at home.

_____

_____

_____

List any behaviors that you would like to change.

Additional information you would like me to know.

Psychiatrist or psychiatric medication prescriber _____ (PHYSICIAN'S NAME) _____ (PHONE)

Primary care physician _____ (PHYSICIAN'S NAME) _____ (PHONE)

Emergency Contact _____ (NAME) _____ (PHONE)

PLEASE BRING THIS WITH YOU TO YOUR FIRST APPOINTMENT.
THANK YOU!