Johns Creek Psychology

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Client Information and Registration

Please read and complete this form. Thank you.
Today's Date _____

Client's name _____ **Date of Birth** _____ **Age** _____ **Gender**: Male/Female
(Last) (First) (M.I.)
Address _____
City _____ State _____ Zip_____
Phone number(s): Home (____) _____ Work (____) _____ Cell/Pager (____) _____
Do we have permission to contact you at any of the above numbers? Yes___ No___ If no, explain: _____
Employer/School _____ Social Security Number _____
Marital Status: Married/Partnered/Single/Sep/Widow

Please complete the below information if the client is a minor

Mother's/Guardian's Name _____
Address (if different from client's) _____
City _____ State _____ Zip_____
Phone number(s): Home (____) _____ Work (____) _____ Cell/Pager (____) _____
Do we have permission to contact you at any of the above numbers? Yes___ No___
Marital Status: Married/Partnered/Single/Sep/Widow/Divorce
Social Security Number _____ Employed: Full Time/Part Time/ NA Employer _____

Father's Name _____
Address (if different from client's) _____
City _____ State _____ Zip_____
Phone number(s): Home (____) _____ Work (____) _____ Cell/Pager (____) _____
Do we have permission to contact you at any of the above numbers? Yes___ No___
Marital Status: Married/Partnered/Single/Sep/Widow/Divorce
Social Security Number _____ Employed: Full Time/Part Time/ NA Employer _____

If Parents live at separate addresses, which address do we use for statements? Mother ___ Father ___
Who is the custodial parent for child? Mother ___ Father ___ Joint ___
If you were referred by a doctor/agency may we thank them for the referral? Y/N Referral Name _____

Emergency Contact Information (to notify in case of emergency)
Name: _____ Relationship: _____
Phone number(s): Home (____) _____ Work (____) _____ Cell/Pager (____) _____
Address (if different from client's) _____

Insurance Information (please provide insurance card)

Policy holder's name _____ Relationship to client: Self/Spouse/Parent/Other

Address of insured person: Same as client's _____ client's mother _____ client's father _____

Policy holder's social security number_____ **Date of Birth** _____ Gender: M/F

Name of employer (or group) insurance is supplied through _____

Address _____

City _____ State _____ Zip_____

Insurance ID#_____ Group/Plan#_____

Co-pay $_____ Deductible? Yes___ No___ Amount $_____

Authorization Required? Yes___ No___ Authorization # _____

Number of Sessions Authorized _____ Maximum Number of Sessions Allowed Per Year _____

Phone number to verify benefits (____) _____

Is the client covered under a secondary insurance policy? Yes___ No___ If yes, please see the applicable paragraph under the Insurance Reimbursement section in the following agreement.

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Child and Family History

Date:_____

Child's Name:_____ **Date of Birth:**_____ **Age:**_____

Social Security #:_____ **Gender:** Male Female **Race:**_____

Address:_____ **Phone #:**_____

School:_____ **Grade:**_____ **Is child in Special Education?** yes no

Mother's Name:_____ **Age:**_____ **Education:**_____ **Annual Salary:**_____

Place/Type of Employment:_____

Father's Name:_____ **Age:**_____ **Education:**_____ **Annual Salary:**_____

Place/Type of Employment:_____

Are the parents (circle which) - ***Married*** ***Separated*** ***Divorced*** ***Never Married to One Another***

Is there another legal guardian besides the parent(s)? yes no **If yes, please state name, address, phone number, and relationship to child (e.g., foster parent, grandparent, etc.):**_____

_____

Is the child adopted? yes no **If yes, age when adopted:**_____

Please list all other adults and children living in the home:

Name	*Age*	*Relationship to this child*

Name of person completing this form:_____ **Relation to child:**_____

_____

Describe the problem(s) your child is having and when the problem(s) began:

What issues, situations, or other problems have contributed to this difficulty?

What kinds of help do you expect? ***Listening*** ___ ***Emotional Support*** ___ ***Feedback*** ___ ***Information*** ___
Increased Awareness ___ ***Help with Problem-solving*** ___ ***Other*** _____

DEVELOPMENTAL and MEDICAL HISTORY

Pregnancy and Delivery:

Length of pregnancy (e.g., full term, 40 weeks, 32 weeks, etc,):_____ **Length of delivery (in hours):**_____

Mother's age when child was born:_____ **Child's birth weight:**_____ **Was pregnancy planned?** yes no

Please *circle* any of the following that occurred during pregnancy or delivery:

Unusual bleeding	Excessive weight gain (more than 30 lbs.)	Toxemia/preeclampsia
Rh factor incompatibility	Frequent nausea or vomiting	Serious illness or injury
Took illegal drugs	Used alcoholic beverages (amount_____)	Smoked cigarettes

Took prescription drugs (name of medications:_____)

Medication to ease labor pains	Forceps used during delivery	Induced delivery
Breech delivery	Cesarean section	Other problems_____

Please *circle* any of the following conditions if they affected your child during delivery or within the first few days after birth:

Injured during delivery	Heart or lung distress during delivery	Delivered with cord around neck
Needed oxygen	Trouble breathing following delivery	Was cyanotic, turned blue
Was jaundiced, turned yellow	Had an infection	Had seizures
Was given medications	Born with a congenital defect	Was in hospital more than 7 days

Infant Health and Temperament:

Please *circle* any of the following if they describe your child's behavior during his/her first 12 months:

Difficult to feed	Difficult to get to sleep	Colicky
Difficult to put on a schedule	Alert	Cheerful
Affectionate	Sociable	Easy to comfort
Difficult to keep busy	Overactive, in constant motion	Very stubborn, challenging

Early Developmental Milestones:

At what age did your child first accomplish the following:

Smiled _____ Sat without help _____ Crawled _____ Stood _____

Fed self _____ **Walked alone** _____ **Said first word** _____ **Said phrases** _____

Bowel trained, day and night _____ **Bladder trained, day and night** _____ **Dressed self** _____

How do you feel your child developed? ____ **Faster than average** ____ **Average** ____ **Slower than average**

Health History:

Child's Pediatrician / Family Doctor:_____ **Date of last physical exam:**_____

At any time has your child had the following:

	Never	Past	Present
Asthma	O	O	O
Allergies	O	O	O
Diabetes, Arthritis or other chronic illnesses	O	O	O
Epilepsy or seizure disorder	O	O	O
Febrile seizures	O	O	O
Chicken pox or other common childhood illness	O	O	O
Heart or blood pressure problems	O	O	O
High fevers (over 103°)	O	O	O
Broken bones	O	O	O
Severe cuts requiring stitches	O	O	O
Head injury with loss of consciousness	O	O	O
Lead poisoning	O	O	O
Surgery	O	O	O
Lengthy hospitalization	O	O	O
Speech or language problems	O	O	O
Chronic ear infections	O	O	O
Hearing difficulties	O	O	O
Eye or vision problems	O	O	O
Fine motor / handwriting problems	O	O	O
Gross motor difficulties, clumsiness	O	O	O
Appetite problems (overeating or undereating)	O	O	O
Sleep problems (falling asleep, staying asleep)	O	O	O
Soiling problems	O	O	O
Wetting problems	O	O	O
Other health difficulties (please describe)			

List both prescription and over-the-counter medications your child is presently using for any physical conditions:

Your child's overall general health is ____ **Excellent** ____ **Good** ____ **Fair** ____ **Poor**

Is their a pattern of physical illness in your family which keeps repeating (e.g., heart disease, cancer, seizures, etc.)? If so, what?

Psychological Treatment History:

Has your child ever been in counseling before? yes no **If so, with whom?**_____

What was the primary problem for which he/she was in counseling?_____
_____
_____

When was the counseling?_____ **For how long?**_____ **What was the outcome?**_____
_____

Has your child ever been hospitalized for emotional problems and/or alcohol/drug treatment? yes no
If so, when _____, **where** _____, **outcome** _____
_____

What medications has your child taken in the past for emotional problems?_____

What medications is your child currently taking for emotional problems?_____

Who is prescribing these medications?_____

Has your child ever completed psychological testing? yes no **If so, with whom?**_____
When?_____ **What was the diagnosis or recommendations?**_____
_____

Is there a family history of emotional or mental illness in your family? yes no **If yes, what types of problems and which family members suffered from these problems?**_____
_____
_____

EDUCATION

What is the highest grade your child has completed?_____

Does he/she have any learning problems in school? yes no **If yes, what are the problems?**_____

Has he/she ever repeated or skipped a grade? yes no **If yes, which one(s)?**_____

How has his/her attendance been?_____ **What types of grades?**_____ **Have the grades changed a lot?**_____

Does he/she have any behavior or discipline problems at school? yes no **If yes, what problems?**_____
_____

Has he/she ever had psychological or educational testing for learning or behavior issues at school? yes no
If yes, for what issues?_____

What types of extracurricular school activities does your child participate in (e.g., clubs, band, drama, etc.)?_____
_____

Is there any family history of learning or school behavior problems in the family? yes no **If yes, what were/are the problems?**_____
_____

SOCIAL HISTORY

What are your child's major strengths?_____

_____

What are your child's major weaknesses?_____

_____

How many close friends does your child have? none 1 2 3 4 or more

Does your child have other friends besides those you would classify as "close" friends? yes no

What is the age range of his/her friends?_____ **Are most of the friends** older, younger **or** same age **(circle which)?**

How does your child get along with his/her friends?_____

Has there been a change in his/her circle of friends lately? yes no **If yes, what has been the change?**_____

_____

Do his/her friends tend to get into trouble? yes no **Does your child belong to a gang?** yes no

Does your child date? yes no **If yes, do you have any concerns about the dating relationships, and if so, what are these concerns?**_____

What losses, changes, crises, and transitions do you believe have significantly impacted your child's life (e.g., divorce, arrests, graduation, moves, death in family, etc.)?_____

_____

_____

Is there anything else about your child's lifestyle, including the family, that would be helpful for your counselor to know?_____

_____

LEGAL HISTORY

Has your child ever been involved with the legal system? yes no **If yes, in what way(s)?**_____

_____

Is your child currently involved in the legal system? yes no **If yes, in what way?**_____

_____

Are there currently criminal and/or civil cases pending? yes no **If yes, what are the charges?**_____

_____

Does your child currently have probation or parole officer? yes no If yes, who?_____

Do you anticipate your child being involved in further legal action in the future (are there any cases not yet filed but which may be filed in the future, please specify)?_____

Has anyone else in your family been involved with the legal system (criminal, divorce, custody, civil, etc.)? yes no
If yes, please explain who and in what way:_____

_____

_____

FAMILY

With whom does this child live (e.g., both parents, mother, foster parents, grandmother, etc.):_____

Has he/she ever lived away from his/her parents? yes no **If yes, under what circumstances?**_____

Does he/she have siblings (brothers and sisters), half-siblings, or step-siblings who do not live with him/her? yes no

Who is typically the disciplinarian in the home?_____

What types of discipline are typically used (e.g., restrictions, spanking, time out, rewards, etc.)?_____

_____

What experiences and events in the family (e.g., discipline, favoritism, trauma, affection, loss of affection, etc.) have been important in your child's life?_____

_____

Has your child or any other person in your family, including your self, experienced any of the following problems?

Concern	Person(s) who experienced this
Mental illness	_____
Depression	_____
Neglect	_____
Sexual dysfunction	_____
Financial difficulty	_____
Emotional abuse	_____
Physical abuse	_____
Sexual abuse	_____
Alcohol abuse	_____
Drub abuse	_____
Other:_____	_____

SUBSTANCE ABUSE

Please check all of the substances your child has used, past and present:

	Past	Now		Past	Now		Past	Now
Alcohol	____	____	**PCP**	____	____	**Ecstasy**	____	____
Marijuana	____	____	**Cocaine/Crack**	____	____	**Sedatives**	____	____
Heroin	____	____	**Opiates**	____	____	**Inhalants**	____	____
LSD	____	____	**Amphetamines**	____	____	**Barbiturates**	____	____
Nicotine	____	____	**Caffeine**	____	____	**Designer drugs**	____	____
Other (please specify:_____**)**				____	____			

When did your child first use alcohol or drugs?_____ **How often does he/she use?**_____

How much does he/she use?_____ When was it last used?_____

Does he/she use alone, with friends, or with family members?_____

Has he/she ever received treatment for substance abuse? yes no **If yes, when and where?**_____

Does anyone else in the family use alcohol or drugs? yes no **If yes, who and what do they use?**_____

_____

BEHAVIORAL and EMOTIONAL CONCERNS

Please check any of the following if your child used to exhibit and/or presently exhibits any of these problems:
(Do not check if your child never exhibited the problem. "Now" means within the last 3-6 months)

	Past	Now
Thoughts of hurting self	___	___
Thoughts of committing suicide	___	___
Plans to commit suicide	___	___
Attempts to commit suicide	___	___
Threats to commit suicide	___	___
Actually harmed someone	___	___
Thoughts of harming someone	___	___
Plans to harm someone	___	___
Attempts to harm someone	___	___
Threats to harm someone	___	___
Depressed or irritable mood most of the day for at least 2 weeks	___	___
Markedly lower interest or enjoyment in almost all activities	___	___
Significant weight loss, when not dieting	___	___
Significant weight gain	___	___
Decreased or increased appetite nearly every day	___	___
Insomnia at night or excessive sleep during the day, nearly every day	___	___
Agitated or excessive movement nearly every day	___	___
Lethargic, sluggish, slow moving nearly every day	___	___
Fatigue and loss of energy nearly every day	___	___
Feelings of worthlessness or excessive, inappropriate guilt nearly every day	___	___
Diminished ability to think or concentrate nearly every day	___	___
Recurrent thoughts of death	___	___
Recurrent thoughts of suicide	___	___
Was very depressed every day for at least two weeks	___	___
Was somewhat depressed or irritable more days than not over past 12 months	___	___
Mood was unusually giddy, joyous or ecstatic for at least 1 week	___	___
Mood was persistently expansive (felt super-human or able) for at least 1 week	___	___
Mood was abnormally and persistently irritable for at least 1 week	___	___
During the week or more he/she showed one of the above 3 moods did he/ he:		
Have inflated self-esteem or felt grandiose about self	___	___
Show decreased need for sleep	___	___
Was more talkative than usual and seemed pressured to keep talking	___	___
Skip from one idea to another as if his/her ideas were flying rapidly by	___	___
State that his/her thoughts seemed to be racing	___	___
Become unusually persistent in accomplishing tasks	___	___
Seem very agitated, overly active, or abnormally restless	___	___
Showed excessive involvement in pleasurable but potentially harmful activities	___	___
Excessive anxiety and worry about a number of event or activities	___	___
Anxiety on most days for at least 6 months	___	___
Restless and feels on edge	___	___
Easily fatigued or tired	___	___
Difficulty concentrating or mind going blank	___	___
Irritability	___	___
Muscle tension	___	___
Difficulty falling asleep, staying asleep, or restless sleep	___	___
Unreasonable fear in social settings where others may notice or scrutinize him/her	___	___
Strong fear of being humiliated or embarrassed in front of others	___	___

	Past	Now
Unreasonable, excessive fear of an object or situation (e.g., animal, heights, etc.)	____	____
Recurrent, excessive distress when separated from home or parent	____	____
Persistent worry that parent will leave or he/she will lose parent	____	____
Nightmares	____	____
Repeated complaints of headaches, stomachaches, nausea or vomiting	____	____
Repeated concerns about having a physical disorder or disease	____	____
Compulsively checks, counts, puts in order, or cleans, often in rigid fashion	____	____
Hears voices or sees things that are not really there	____	____
Believes that others are trying to harm him	____	____
Believes that others are controlling his mind	____	____
Is extremely suspicious of others	____	____
Others view his behavior and manner of speaking as odd or "crazy"	____	____
Often loses temper	____	____
Often argues with adults	____	____
Often actively defies or refuses adults' requests or rules	____	____
Often deliberately annoys people	____	____
Often blames other for his/her mistakes or misbehavior	____	____
Is often touchy or easily annoyed by others	____	____
Is often angry or resentful	____	____
Is often spiteful or vindictive	____	____
Often bullies, threatens, or intimidates others	____	____
Often initiates physical fights	____	____
Has used a weapon that can cause serious physical harm (e.g., gun, bat, brick, etc.)	____	____
Has been physically cruel to people	____	____
Has been physically cruel to animals	____	____
Has stolen while confronting a victim (e.g., mugging, purse snatching, etc.)	____	____
Has forced someone into sexual activity	____	____
Has deliberately engaged in fire setting with intention of causing damage	____	____
Has deliberately destroyed others property (other than by fire setting)	____	____
Has broken into someone else's house, building, or car	____	____
Often lies or "cons" to obtain goods or favors and avoid obligation	____	____
Has stolen items without confronting a victim (e.g., shoplifting, forgery, etc.)	____	____
Often stays out at night despite parental prohibitions	____	____
Has run away from home, foster care, group home overnight	____	____
Is often truant from school	____	____
Often fails to give close attention to details or makes careless mistakes	____	____
Often has difficulty sustaining attention in tasks or play activities	____	____
Often does not seem to listen when spoken to directly	____	____
Often does not follow through on instructions and fails to finish work	____	____
Often has difficulty organizing tasks and activities	____	____
Often avoids, dislikes or is reluctant to engage in tasks requiring sustained effort	____	____
Often loses things necessary for tasks or activities (e.g., books, tools, pencils, etc.)	____	____
Is easily distracted by extraneous stimuli	____	____
Is often forgetful in daily activities	____	____
Often fidgets or squirms in seat	____	____
Often leaves seat in class or other situations where remaining seated is expected	____	____
Often runs or climbs excessively or feel restless and wants to move about	____	____
Often has difficulty playing quietly	____	____
Often talks excessively	____	____
Often blurts out answers before the other person has finished talking	____	____
Often interrupts or intrudes on others	____	____
Often has difficulty awaiting his/her turn	____	____

On the previous two pages a number of emotional and behavioral problems were presented. Please go back and circle those problems which you consider to be the most severe.

When did you first notice these problems?

How old was your child when these problems started?

When was the last time you noticed these problems?

Have the problems been so severe that they have affected his/her family, school, and/or social life?

How has your child's and your family's life been effected by these problems?

What types of help have you sought for these problems?

Is there anything else that might be helpful that we have not asked?

Please sign:_____