Johns Creek Psychology

Lorna L. Benbenisty, Ph.D. • Audrey Bloom, Ph.D. • Sonja Contin, Psy.D. • Saori Maruyama, Ph.D. • Diane Sperry, Ph.D.
10475 Medlock Bridge Road, Building 300, Suite 315, Johns Creek, GA 30097 • 678-935-9567 (phone) • 678-935-9568 (fax)

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) _____

Medical Information

Client's Physician _____ Phone Number (____) _____

List any current or significant past medical problems the client has experienced including head injuries, surgeries, hospitalizations, seizures, major illnesses

_____

_____

_____

_____

_____

_____

List any medications that the client is currently taking or has taken in the past six months and the condition for which it is taken_____

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_____

_____

_____

_____

_____

Brief History of Problems

Please describe your presenting concerns: _____

_____

_____

_____

_____

_____

Briefly describe your goals for therapy or assessment?

_____

_____

_____

_____

_____

Please describe any past history of psychological services:

_____

_____

_____

_____

_____

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.

Brief History of Problems

Please check all that apply now and in the past. Circle those problems for which you are currently seeking treatment.

Difficulty With	Now	Past	Difficulty With	Now	Past
Abdominal Distress	☐	☐	Hyperactivity	☐	☐
Aggressiveness/Anger	☐	☐	Language Problems	☐	☐
Alcohol Abuse/addictions	☐	☐	Learning Problems	☐	☐
Allergies	☐	☐	Legal Problems	☐	☐
Anxiety/Nervousness	☐	☐	Marital Problems	☐	☐
Attention/Concentration Problems	☐	☐	Mood Changes	☐	☐
Authority Problems	☐	☐	Oppositional/Defiant	☐	☐
Communication Problems	☐	☐	Pain/Physical Discomfort	☐	☐
Confusion	☐	☐	Panic Attacks	☐	☐
Death of a Loved One	☐	☐	Paranoid Feelings	☐	☐
Depression	☐	☐	Poor Appetite	☐	☐
Disorientation	☐	☐	Poor Memory	☐	☐
Divorce	☐	☐	Recent Life-style Change	☐	☐
Drug Abuse	☐	☐	Repetitive Thoughts/Behaviors	☐	☐
Easily Distracted	☐	☐	Restlessness	☐	☐
Eating Problems	☐	☐	School Problems	☐	☐
Excess Stress	☐	☐	Relationship Difficulties	☐	☐
Fainting/Dizziness	☐	☐	Self Esteem Low	☐	☐
Family Conflict	☐	☐	Sexual Dysfunction	☐	☐
Feeling Manic	☐	☐	Shyness	☐	☐
Finances/Money Management	☐	☐	Sleep too Much	☐	☐
Friendship Problems	☐	☐	Sleeplessness	☐	☐
Hallucinations	☐	☐	Strong Fears	☐	☐
Head Injury	☐	☐	Suicide Attempts	☐	☐
Health Problems	☐	☐	Suicidal Thoughts	☐	☐
Hearing Problems	☐	☐	Very Low Energy	☐	☐
History of Abuse	☐	☐	Violent/Threatening Behavior	☐	☐
Homicidal Thoughts	☐	☐	Vision Problems	☐	☐
Hopelessness	☐	☐	Weight Issues	☐	☐
Hurting Self	☐	☐	Work Problems	☐	☐