Johns Creek Psychology

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Client Information and Registration

Please read and complete this form. Thank you.
Today's Date 今日の日付_____

Client's name お名前_____ Date of Birth 生年月日 _____ Age 年齢_____

Gender 性別: Male 男 /Female 女

Address 住所
_____

City 市_____ State 州 _____ Zip 郵便番号_____

Phone number(s)電話番号: Home 自宅(____) _____ Work 職場(____) _____

Cell/Pager 携帯(____) _____

Do we have permission to contact you at any of the above numbers? 上記の電話番号にご連絡してもよろしいですか？
Yes はい___ No いいえ___ If no, explain 「いいえ」とお答えになった理由: _____

Employer/School 勤め先_____

Social Security Number ソーシャルセキュリティー番号_____

Marital Status: Married 既婚/ Divorced 離婚/ Single 独身/ Sep 別居/ Widow 死別

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 緊急時の連絡先(to notify in case of emergency)

Name 名前: _____ Relationship 関係: _____

Phone number(s)電話番号: Home 自宅(____) _____ Work 職場(____) _____

Cell/Pager 携帯(____) _____

Address (if different from client's) 住所

_____

Medical Information

Client's Physician かかりつけの医師_____ Phone Number 電話番号(____) _____

List any current or significant past medical problems the client has experienced including head injuries, surgeries, hospitalizations, seizures, major illnesses 現在、または過去の医療的な問題（例えば、頭部の怪我、手術、入院、発作、病気など）

_____
_____
_____
_____
_____
_____
_____
_____

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 現在使われている、または過去６ヶ月に使われていたお薬とその理由

_____
_____
_____
_____
_____
_____
_____
_____

Brief History of Problems

Please describe your presenting concerns 現在の心配事:

_____
_____
_____
_____
_____
_____
_____

Briefly describe your goals for therapy or assessment　カウンセリングの目的

Please describe any past history of psychological services:　過去に受けられたカウンセリング

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	☐	☐