4Thought Counseling, LLC
11340 Lakefield Drive, Suite 200 Johns Creek, GA 30097

Today's Date:_____/______/______

**CLIENT INFORMATION SHEET**

Name _____________________________________________ Date of birth _____/_____/_____ Age_____________

Client Social Security #: _________________Sex: Male/ Female Race/Ethnicity (optional) _______________________

Marital Status: Single Married Separated Divorced

Address _______________________________________________________________________________________

City/State/Zip _______________________________________ Home Phone _______________________________

Email Address________________________________________ Cell/Work Phone ___________________________

Occupation _______________________________Employers Name: ______________________________________

Name of your Primary Care Physician _____________________________________________________________
PCP Phone: _____________________ PCP Fax______________________________________

Referred By: ___________________________

May I contact or leave messages for the client or parent/Legal Guardian at the numbers listed above? Yes / No

If Client is under age 18 Please provide the Name of Parent/Legal Guardian Bringing Child to Appointment:
_________________________________________________________________________________

Insurance Information

Insurance Company Name: _____________________Phone # for Mental Health Benefits/Services: ________________

**Policyholder's Name: _____________________________________ Date of Birth: ____ /____/____ Sex: M / F**

Policyholder's Address: ___________________________________________________________________________

Policyholder's SSN: ____________________________________ Marital Status: ______________________________

Member ID Number/Medicaid#: ______________________________ Group/Plan/Policy#____________________

Authorization for services may be required prior to treatment. Did you obtain authorization for services from your insurance company? Yes / No / Not required Authorization #: _____________________________# of sessions approved ___

Policyholders' Employer (Name & Address) __________________________________________________________
_____________________________________________________________________________________________

Other people living in the home:

| Name | Age | Relationship to Client |
| --- | --- | --- |
| | | |
| | | |
| | | |

Emergency Contact: _____________________________________ Relationship_________________________________
Complete Address: _______________________________________________________________________________
Home Phone: ________________________Work Phone: ____________________ Cell Phone: __________________
Spouse's Name (If not Emergency Contact): _____________________________________________________________
Home Phone: _____________________Work Phone: ________________Cell Phone:_________________________

**PATIENT SELF REPORT**

Patient Name: ______________________________Age:__________ Date: ____________________________________

Name of person completing this form (if not patient): ______________________________________________________

1. Briefly describe the problem which brought you here today._______________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

2. Check any issues you are having difficulty with.

| **ADHD** | **Depression** | **Anxiety** | **Relationship** |
|---|---|---|---|
| hyperactive | sad | excessive worry | marital/significant other |
| impulsive | sleep problems | panic attacks | parenting |
| under achievement | neg. thinking | irrational fear | difficulty with friends |
| non-compliant | poor concentration | obsessions | work/school problems |
| inattentive | hopeless/worthless | social isolation | personal growth |
| poor concentration | mood swings | phobias | grief/loss |
| disorganized | guilt | compulsive | bullying/teasing |

| **Anger** | **Addictions** | **Abuse** | **Other** |
|---|---|---|---|
| short-fused | alcohol | physical | agitated |
| temp. tantrums | drugs | emotional | mania |
| impulse control | gambling | domestic violence | paranoia |
| violent/assaultive | relationships/sex | rape | delusions |
| runaway risk | eating disorders | sexual | tics/tourette's |
| fighting | cyber/internet | dissociative | cutting behavior |
| irritable | spending | nightmare/flashback | oppositional |
| | | | appetite changes |
| | | | eating disorders |
| | | | pregnancy loss |
| | | | abortion |

3. Are you now or have you ever had thoughts of hurting yourself or someone else? yes no

**Past Treatment**

4. Have you ever been treated for psychiatric, substance abuse, emotional, or behavioral problems in the past? yes no

5. If yes, when, where, and with whom? ____________________________________
Inpatient____________________ Outpatient ________________________________
counselor psychologist psychiatrist substance abuse counselor

6. Did you find past treatment helpful? yes no

if yes, how'? __________________________________________________________
if no, why not? ________________________________________________________

7. Please list any medications given: ________________________________________
________________________________________________________________

8. Are you currently under the care of a psychiatrist or therapist for your current problem? yes no

9. Are you currently taking any medications for psychiatric problems? yes no
If yes, please list: ________________________________________________________
________________________________________________________________

**Medical Problems**

10. Do you have any current medical problems? yes no
If yes, please list: ____________________________________________________

11. When was the last time you were seen by a doctor? ______________________
12. Would you like information from today's visit communicate
**Therapist Comments**
with your medical doctor? yes no

13. Are you currently taking medication for
medical problems? yes no
If yes, please list medication, dosage, and purpose: ___________________________
________________________________________________________________

14. Do you have any allergies and/or medication allergies? yes no
If yes, please list: ____________________________________________________

15. Do you have a history of head injury, seizures or
loss of consciousness? yes no
Please explain: _______________________________________________________

16. (Women only) Are you pregnant? yes no

17. Do you have pain management issues? yes no

**Substance Abuse**

18. Have you been treated for drug, alcohol abuse, or other addictions (food, gambling, sex)? yes no

19. Do you currently attend support groups? yes no

20. Circle the following you have used in the past 30 days: tobacco, alcohol, rnarijuar1a, tranquilizers, sleeping pills, pain killers, heroin, cocaine/crack, amphetamines/speed, methadone, LSD, PCP, ecstasy, inhalants.

2l. Have you experienced withdrawal symptoms? yes no
If yes, circle all which apply: withdrawal, headaches, nausea, vomiting, tremors, seeing things, hearing things.

22. Have you ever been arrested for a DUI? yes no

**Legal Issues**

23. Do you have current legal problems? yes no
If yes, describe: _____________________________________________________
________________________________________________________________

24. Are you currently on probation/parole? yes no

25. Do you haves DFACS worker? yes no

**Employment/Education**

26. Circle current employrnent status; full time, part time, unemployed, homemaker, student, disabled, retired.

27. Are you currently on leave from work
or seeking medical leave/disability? yes no
lf yes, do have paperwork that needs to be completed? yes no
lf yes, please give clinician paperwork at beginning of session!

28. Circle educational background:. current student, did not complete high school, graduated high school, GED, some college, graduated college, advanced degree.

29. Did you experience difficulties in school? yes no

**Family/Relationships**
**Therapist Comments**

30. Please list anyone who lives in your home, his/her age, and relationship,
______________________________________________
______________________________________________

31. Does anyone in your immediate family have-psychiatric, emotional, substance abuse, or behavioral problems? yes no

32. ls your immediate family supportive of you seeking treatment? yes no

33. Does anyone in your extended family have psychiatric, emotional, substance abuse, or behavioral problems? yes no
lf yes, please describe: ______________________________

34. Do you have any domestic violence history or current issues? yes no

35. Do you have any history of sexual and/or physical abuse? yes no

36. Is your support network (Circle one) Good? Fair? Poor?
(i.e. friends, family, neighbors, religious organizations)
Please list: ______________________________

37. What are your hobbies/interests? ______________________________
______________________________________________

38. Do you have difficulties or concerns about how you get along with other people? yes no

39. Are you having difficulties with spiritual or religious matters? yes no

40. Do you have any sexual orientation/gender issues or concerns? yes no

**Treatment Access/Mobility**

41. Are there any financial concerns that would affect your ability to access treatment'? yes no

42. Do you have access to transportation? yes no

43. Do you have any disabilities, special needs, or other restrictions that may impact your treatment or access to treatment? yes no

44. Based on the information you provided in this self report, what would you like to see changed? ____________________________________________________
______________________________________________________________________
______________________________________________________________________

45. In your opinion, what could block or prevent that change? __________________
______________________________________________________________________
______________________________________________________________________

_________________________________________________________

Patient (or person completing this form) signature    Date

_________________________________________________________

Clinician Signature/Credentials    Date