4Thought Counseling, LLC
6470 East Johns Crossing, Suite 160 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 with your medical doctor? yes no

13. Are you currently taking medication for medical problems? yes no
lf 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.

21. 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

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