ATLANTA COUNSELING CENTER
6111-C Peachtree Dunwoody Rd., Atlanta, Georgia 30328
Telephone (770) 396-0232

Therapist ________________________ Date _____________

Patient Name ____

M/F_____ Birth Date ____________ SS# _______ ___________ _______

Address ____

City ________________ State _________ Zip ____________

Phone (H) _____________ (W) _____________ May we contact you at work? Yes/No
(C) ____________________

Name of Person Responsible for Payment __________________________

Address (if different from above) ____

City _______________ State ________ Zip __________ Phone #_________________

Do you have insurance to cover Mental Health Services? Yes ____ No ____

Insurance Company _____________________ Medicare ________ Medicaid ________

Do you belong to a Managed Care Plan ? Yes _______ No _______

Which Company ______________________________

If your clinician is a provider with the following insurance carriers we will file your claim:

Blue Cross Blue Shield of GA
Medicaid
Medicare
Principal

United Healthcare PPO
Cigna PPO
Magellan
Humana PPO

If you are with one of the above companies please provide your insurance card to be photocopied for our files. Due to complex insurance programs, it is the patient's responsibility to verify coverage and obtain authorization. Sign below to signify your consent for each session to be filed with your insurance carrier, if applicable.

Regardless of insurance coverage, if your account has a balance you are personally responsible for timely payment. Statements will be mailed to your home on a monthly basis.

___________________________________ _________________
Signature Date

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To be filled out by parent or guardian requesting services for a minor youth.

Note: Information requested on this questionnaire will be helpful in understanding your youth. Feel free to add as much information as you think is helpful in understanding the background and nature of the problem. We maintain the highest standards of professional confidentiality. Information about any particular individual can be released only with the written consent of that person, or in the case of a minor, his or her parent or guardian.

Today's Date ____________________

Name of youth ___________________________________ _______________________________

Age ____________________________ Date of Birth __________________________________

Parents' names ____

Address ____

City, State & Zip Code ____

Home Telephone Number ____

Home Numbers (Mother) ________________________ (Father) _________________________

Office Numbers (Mother) ________________________ (Father) _________________________

Cell Numbers (Mother) __________________________ (Father) _________________________

Who referred you ____

Describe the problem. If possible, list questions for which answers are sought: ______________

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Have there been any previous psychological, psychiatric or neurological evaluations? ____ If so, please list names, addresses, and dates of contact.

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In keeping with Georgia state law, the Atlanta Counseling Center will report all suspected cases of child abuse.

List all people now living in the household; then draw a line and list others who have lived there during the child's lifetime.

Name	Relationship to Youth	Age	Highest School Grade	Occupation

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

Please describe if any children living in the household were adopted, if there have been previous marriages, or if there have been any deaths in the immediate family.

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MEDICAL HISTORY: List all major illnesses, operations and injuries, past or present. Indicate age when occurred and describe how severe. Please pay special attention to head injuries and any time when your child was unconscious, or had convulsions, or was delirious, or had a very high fever.

____

____

____

Indicate any continuing medication treatment. _______________________________________

____

Allergies? ____

How is the child's vision? ____

How is the child's hearing? ____

Describe any difficulty pronouncing words or speaking. ____________________________

____

____

Describe previous speech or hearing therapy, if any. ________________________________

____

Describe any problems with awkwardness or clumsiness. ____________________________

____

____

____

When did your child last have a physical examination? _____________________________

Name of physician____

Address ____

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DEVELOPMENTAL HISTORY: While some of this information might seem "out of date", it may be helpful in evaluating your child comprehensively.

Did pregnancy with this child proceed typically? ____

Any complications during or immediately following the delivery? _________________________

How did the first year go? ____

Colic?__________________ Feeding problems? ____

Please describe any difficulty with or concern about developmental milestones, such as walking,

talking, toilet training or other ____

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CURRENT FUNCTIONING AND HABITS:

Describe your child's appetite and eating habits at present. ________________________________

____

____

Describe nervous habits such as thumb sucking, nail biting, etc. ____________________________

____

____

Describe any other unusual habits or behavior. ____

____

Describe child's sleeping pattern. Are there nightmares or night terrors now or in the past? ____

____

____

Describe child's level of activity and vigor. ____

____

____

Describe your method of discipline and how your child reacts to such discipline. Any

stubbornness? ____
____

____

____
____

How does your child get along with other children in the family? _______________________

____

How does your child get along with others his/her age? A leader? A follower? Associates with

others who are older? Younger? ____

____

____

____

____

Describe any moody periods. ____

____

Describe any problems in sitting still or paying attention. ____________________________

____

Describe what your child likes to do for fun, special interests, hobbies, etc. __________________

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____

Describe any concerns about sexual activity or identity. ___________________________________-

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____

EDUCATIONAL HISTORY:

Name of School ____________________________________ Grade ______________________

Current School Teacher/Counselor/Principal ____

List previous schools attended with dates ____

____

____

____

Has child repeated a grade? ______________________ If so, when? ________________________

If so, what was the problem? ____

____

____

What are the child's grades like now? ____

____

____

Describe any difficulties in learning at home or in school. ________________________________

____

____

Have there been any discipline or other behavior problems at school? _______________________

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Have there been any discipline or other behavior problems at school? _______________________

If so, please describe. ____

RELIGIOUS BACKGROUND: Describe child's experience (denomination, whether member of a church, attendance at Sunday School and worship services, religious training at home, prayer life, concept of God, etc.)

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How did you hear about us?

Yellow Pages ____ Friend/Relative ____ Church ____ Doctor ____ Internet _____

Other_____________________

Name of Person who referred you to us: _______________________________________

May we thank them for referring you? Yes ____ No ____ Phone # ______________

Address_________________________________City________________State_________

Zip____________

I attest that I **(please circle)** have/do not have **(please circle)** full/partial legal authority to make medical decisions for the fore named minor and give my consent for treatment.

We very much appreciate the time you have spent in completing this form. Please add any additional comments below.

Signature ______________________________

Date __________________________________

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The following is a list of common problems. Read each one carefully and circle the number to the right that best describes how much that problem is of concern to you.

0 – Not at all 1 – Mildly 2 – Moderately 3 – Very much 4 – Extremely

1. Feeling low in energy or slowed down.	0	1	2	3	4
2. Dissatisfied with my spiritual life.	0	1	2	3	4
3. Repeated, unwanted thoughts that won't leave my mind.	0	1	2	3	4
4. Loss of control, or fear of losing control of my temper.	0	1	2	3	4
5. Not satisfied with my weight.	0	1	2	3	4
6. Nervousness or shakiness inside.	0	1	2	3	4
7. Troubled by sexual thoughts or behavior.	0	1	2	3	4
8. Drink when troubled or under pressure.	0	1	2	3	4
9. Unusual fears that most people don't have.	0	1	2	3	4
10. Thoughts of ending my life.	0	1	2	3	4
11. Sleep that is restless or disturbed.	0	1	2	3	4
12. Problems with police or legal matters.	0	1	2	3	4
13. Feel withdrawn and/or isolated.	0	1	2	3	4
14. Loss/absence of sexual desire or pleasure.	0	1	2	3	4
15. Other people being aware of my private thoughts.	0	1	2	3	4
16. Feeling hopeless about the future.	0	1	2	3	4
17. Problems with my eating.	0	1	2	3	4
18. Spells of terror or panic.	0	1	2	3	4
19. Feeling shy or uneasy with the opposite sex / same sex.	0	1	2	3	4
20. Drinking or emotional problems in my or my parent's family.	0	1	2	3	4

21. Feeling that I am watched or talked about by others.	0	1	2	3	4
22. Things about my life are too painful to talk about.	0	1	2	3	4
23. Difficulty feeling close to another person.	0	1	2	3	4