

NEW CLIENT REGISTRATION

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Today's Date: _____

Referred by: _____

PERSONAL INFORMATION

Name: _____ Age: _____ Sex: _____

Address: _____ Social Security #: _____

City, State, Zip: _____ Date of Birth: _____

Home Phone: _____ May I call this number? Y N May I leave a message? Y N

Cell Phone: _____ May I call this number? Y N May I leave a message? Y N

Email: _____ May I email you? Y N (Note: Email is not considered secure)

Person responsible for bill: _____ Relationship: _____

Address & Phone of responsible party: _____

EMPLOYER INFORMATION

Employer: _____ Occupation: _____

Address: _____

Work Phone: _____ May I call this number? Y N May I leave a message? Y N

INSURANCE INFORMATION

Primary Coverage

Name of Insured: _____ Social Security #: _____ DOB: _____

Insurance Company: _____

Address: _____ Phone: _____

Subscriber ID#: _____ Group #: _____

Secondary Coverage

Name of Insured: _____ Social Security #: _____ DOB: _____

Insurance Company: _____

Address: _____ Phone: _____

Subscriber ID#: _____ Group #: _____

MEDICAL & REFERRAL INFORMATION

Primary Care Physician: _____

Phone: _____

Other Physician: _____

Phone: _____

May I share session notes with your physicians? Y N

Who referred you? _____

Relationship: _____

HOUSEHOLD INFORMATION

Spouse/Partner Name: _____

Employer: _____

Work Phone: _____

Others in home (name):	Gender:	Age:	Relationship:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EMERGENCY CONTACT

Emergency Contact: _____

Relationship: _____

Address: _____

Home Phone: _____

Work Phone: _____

PERSONAL MEDICAL HISTORY

Have you ever had or do you currently have any of the following (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Head Injury with Loss of Consciousness | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Allergies (Name: _____) |
| <input type="checkbox"/> Memory Problems | <input type="checkbox"/> Allergies to Medications (Name: _____) |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sexually Transmitted Diseases or HIV |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Difficulty urinating or bowel problems (circle which) |
| <input type="checkbox"/> Heart Attack or Heart Problems | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Toxic Reaction to Medications or Drugs | <input type="checkbox"/> Thyroid, Parathyroid, or Adrenal Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Previous therapy <input type="checkbox"/> Psychiatric Hospitalization(s) |
| <input type="checkbox"/> Other medical problems: _____ | |
| _____ | |

Current Medications: _____
