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Licensed Clinical Psychologist

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Client Registration

Today's Date: _____

Identification

Name: _____ Date of birth: _____

Address: _____ Home phone: _____ Msg ok? ____

_____ Work phone: _____ Msg ok? ____

_____ Cell phone: _____ Msg ok? ____

Email: _____ Social Security #: _____

☐ Never ☐ Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Referral

I was referred by: _____ May I have your permission to contact this person to thank them for the referral? Yes ☐ No ☐

Address & phone number of referral source: _____
_____
_____

Coordination of Treatment

Have you had previous psychotherapy? ____
If yes, please provide the therapist's name: _____
Are you being prescribed psychotropic medication (e.g. antidepressants or others)? _____
If yes, please list medications and doses: _____
_____
_____

Have you been prescribed psychotropic medication in the past? _____
If yes, please list: _____
_____
_____

May I have your permission to contact your psychiatrist or other prescribing physician for best coordination of your treatment? _____
Name, address and phone # of psychiatrist or other physician: _____
_____
_____
_____

Health Information

How is your current physical health? ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

Please list any persistent physical symptoms or health concerns:

_____

_____

Do you have any problems with sleep? No

If yes, please check applicable problems below:

☐ sleeping too little ☐ sleeping too much ☐ poor quality sleep ☐ disturbing dreams ☐ other:

Is exercise a regular part of your life? _____ If yes, how many times per week? _____

For how long each time? _____

What kinds of exercise? _____

How do you use alcohol? _____

Do you use other substances besides alcohol? _____

If so, which substances, and how? _____

Work

Occupation: _____ Employer: _____

Address: _____

Emergency Contact

Name: _____ Relationship: _____ Phone #: _____