Deborah L. Carle, Ph.D.
11111 Nall Ave., Suite 224
Leawood, Kansas 66211
Phone: 913-549-4390 Fax: 914-549-4392

ADULT REGISTRATION FOR RETURNING CLIENTS

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Last 4 Digits of Social Security Number: ___ ___ ___ ___

Street Address _____ City_____ State_____ Zip Code _____

Cell Phone _____ Home Phone **(If different from cell)** _____ Work Phone_____

Preferred phone contact: ☐ Cell ☐ Home ☐ Work

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Engaged

Employer: _____ Occupation_____

EMERGENCY CONTACT INFORMATION

Name_____ Relationship to Client _____

Cell Phone _____ Home Phone **(If different from cell)** _____ Work Phone_____

INSURANCE INFORMATION

Primary Policyholder is: ☐ Self ☐ Spouse ☐ Other:_____

- **If the primary policyholder is someone other than yourself, please complete the following:**

Policy Holder's Last Name _____ First Name _____ Middle Initial_____

Phone _____ Date of Birth _____ Last 4 Digits of Social Security Number: ___ ___ ___ ___

Street Address _____ City_____ State_____ Zip Code _____

***Please complete the following <u>ONLY</u> if you are unable to supply a copy of your card.**

Primary Insurance Company Name _____ Phone Number _____

ID # _____ GROUP # _____

Street Address _____City _____State _____ Zip _____

IF YOU DO NOT HAVE SECONDARY INSURANCE, PLEASE SKIP TO PAGE 3

SECONDARY INSURANCE INFORMATION

Secondary Policyholder is: ☐ Self ☐ Spouse ☐ Other:_____

- **If the secondary policyholder is someone other than yourself, please complete the following:**

Policy Holder's Last Name _____ First Name _____ Middle Initial_____

Phone _____ Date of Birth _____ Last 4 Digits of Social Security Number: ___ ___ ___ ___

Street Address _____ City_____ State_____ Zip Code _____

***Please complete the following <u>ONLY</u> if you are unable to supply a copy of your card.**

Secondary Insurance Company Name _____ Phone Number _____

ID # _____ GROUP # _____

Street Address _____City _____State _____ Zip _____

CLINICAL UPDATE

Presenting Problem:
What are the primary concerns, symptoms, or issues that sought you to seek help now?

Family/Living Situation:
Please list others living in the home, ages and their relationship to you:

Physical/Medical Concerns and Medications:

Allergies:

Medical Diagnoses and Date Diagnosed:

Hospitalizations and Surgeries (please include dates):

Medications/Supplements: (*Please list*) **OR** ☐ **Check if list is attached**

Medication/Supplement	Dose	Reason Prescribed	Medication/Supplement	Dose	Reason Prescribed

Alcohol/Drug Use:
Have you used or do you currently use alcohol or drugs? ☐ No ☐ Yes
If yes, please complete the following:

Substance	Amount	Frequency	Age Started Using	Age Stopped Using

Goals:
Please list the goals would you like to accomplish through the therapy process: