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ADULT REGISTRATION FORM

Last Name _____ First Name _____ Middle Initial _____

Preferred Name _____ Last 4 Digits of Social Security Number: ___ ___ ___ ___

Date of Birth _____ Age _____ Gender _____ Race _____

Street Address _____City _____State _____ Zip _____

Cell Phone _____ Home Phone **(If different)** _____ Work Phone _____

Please circle preferred contact phone: ☐ Cell ☐ Home ☐ Work

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

Referral Source: _____

Employer: _____ Occupation _____

FINANCIALLY RESPONSIBLE PARTY (If different from above)

Last Name _____ First Name _____ Middle Initial _____

Date of Birth_____

Street Address _____

City_____ State_____ Zip Code _____

Cell Phone _____ Home Phone **(If different)** _____ Work Phone _____

Employer_____ Occupation_____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship to Client _____

Cell Phone _____ Home Phone **(If different)** _____ 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 FOLOWING ONLY IF YOU ARE UNABLE TO SUPPLY A COPY OF YOUR CARD.**

Primary Insurance Company Name _____ Phone Number _____

ID # _____ GROUP # _____

Street Address _____City _____State _____ Zip _____

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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 FOLOWING ONLY IF YOU ARE UNABLE TO SUPPLY A COPY OF YOUR CARD.**

Secondary Insurance Company Name _____ Phone Number _____

ID # _____ GROUP # _____

Street Address _____City _____State _____ Zip _____

CLIENT INFORMATION

Presenting Problem

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

How long have these been a problem? _____

Have you had past treatment for these problems? ☐ No ☐ Yes

These problems are: ☐ Mildly Upsetting ☐ Moderately Severe ☐ Very Severe ☐ Totally Incapacitating

Goals

What goals would you like to accomplish through the therapy process:

Psychiatric/Mental Health History *(i.e., therapy/counseling, medication)* ☐ NONE

☐ Outpatient Dates: _____

☐ Partial Hospital/IOP Dates: _____

☐ Inpatient Dates: _____ Hospital(s): _____

Have you ever attempted suicide? ☐ No ☐ Yes If yes, when? _____

Have you ever engaged in any self-harm behaviors? ☐ No ☐ Yes

If yes, when? _____ What type(s)? _____

Are you currently experiencing suicidal ideation? ☐ No ☐ Yes

If yes, do you have a plan for suicide? ☐ No ☐ Yes

Is there any family history of mental health/substance abuse problems or diagnoses? ☐ No ☐ Yes

If yes, please list relative(s) and diagnosis.

Family Information

Name of Spouse/Significant Other:_____

Children (Names and Ages):

Social History

Do you have a social support group (i.e., friends, family support)? ☐ No ☐ Yes

What do you do for pleasure and relaxation? _____

Education

Highest Degree Earned: _____ School: _____

Job History

Current Occupation: _____ Years on the Job: _____

Past Occupation: _____ Years on the Job: _____

Medical History

Allergies: ☐ None

Medical Diagnoses *(please include approximate dates)*: ☐ None

Hospitalizations and Surgeries (please include approximate dates): ☐ None

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:

Type of Substance *(Including Alcohol)*	**Amount**	**Frequency**	**Age Started Using**	**Age Stopped Using**

Legal History

Are you currently involved or do you expect to be involved in any court-related matters? ☐ No ☐ Yes

If yes, what type? _____

Have you ever been arrested? ☐ No ☐ Yes

If yes, for what reason and at what age: _____

Other Information:

Please provide any additional information or concerns you want your psychologist to know.