## Deborah L. Carle, Ph.D. 11111 Nall Ave., Suite 224 Leawood, Kansas 66211

Phone: 913-549-4390 • Fax: 913-549-4392

## **ADULT REGISTRATION FORM**

Last Name	First Name	Middle Initial					
Preferred Name	La	st 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 co	ntact phone: Cell Home	Work					
Marital Status: Single	Married Divorced Sepa	arated Widowed Engaged					
Referral Source:		_					
Employer:	ployer: Occupation						
FIN	IANCIALLY RESPONSIBLE PARTY	(If different from above)					
Last Name	First Name	Middle Initial					
Date of Birth							
Street Address							
City	Sta	ate Zip Code					
Cell Phone	Home Phone (If different)	Work Phone					
Employer	Oc	Occupation					
	EMERGENCY CONTACT I	NFORMATION					
	EWERGENCY CONTACT IS						
Name		ip to Client					

## **INSURANCE INFORMATION**

Primary Policyholder is:	Self Spouse 0	Other:		
If the primary policyh	older is someone othe	er than yourself, please	complete the followin	g:
Policy Holder's Last Name		First Name		Middle Initial
Phone	_ Date of Birth	Last 4 Digits	nber:	
Street Address	0	Lity	State Z	ip Code
*PLEASE COMPLETE THE FOLO	OWING <u>ONLY</u> IF YOU A	RE UNABLE TO SUPPLY	A COPY OF YOUR CAR	D.
Primary Insurance Company	, Name		Phone Number	
ID#		GROUP #		
Street Address	C	ity	State	_ Zip
Secondary Policyholder is:		Other:		
. If the coordon, notice	· •			
If the secondary police		ther than yourself, pleas		
Policy Holder's Last Name	cyholder is someone ot		se complete the follow	ving:
•	cyholder is someone ot	First Name	se complete the follow	ving: _ Middle Initial
Policy Holder's Last Name	cyholder is someone of	First Name Last 4 Digits	se complete the follow	ving: _ Middle Initial nber:
Policy Holder's Last Name	cyholder is someone of  Date of Birth	First Name Last 4 Digits City	of Social Security Num	ving: _ Middle Initial nber: Zip Code
Policy Holder's Last Name Phone Street Address	cyholder is someone of  Date of Birth  OWING ONLY IF YOU A	First Name Last 4 Digits City ARE UNABLE TO SUPPLY	of Social Security Num State	ving: _ Middle Initial nber: Zip Code  D.
Policy Holder's Last Name Phone Street Address *PLEASE COMPLETE THE FOLG	Date of Birth  OWING ONLY IF YOU A	First Name Last 4 Digits City ARE UNABLE TO SUPPLY	of Social Security Num State	ving: _ Middle Initial nber: Zip Code  D.

## **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)
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?

Current Occupation:	Education									
Current Occupation:	Highest Degree Earned:		Sch	nool:						
Past Occupation:	Job History									
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 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.	Current Occupation:		Years on the Job	Years on the Job:						
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 Amount Frequency Age Started Using Age Stopped Using (Including Alcohol)  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.	Past Occupation:				Years on the Job	Years on the Job:				
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Type of Substance		urrently use alcohol or	drugs?	No Yes						
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Other Information: Please provide any additional information or concerns you want your psychologist to know.										
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Please provide any additional information or concerns you want your psychologist to know.	Other Information:									
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