

CLIENT REGISTRATION

(PLEASE PRINT)

Today's Date: / /

Client's full name _____

Home Address: _____ City: _____ Zip: _____

Primary Phone: () _____ cell? / message? 2nd Phone: () _____

Sex: _____ Age: _____ Date of Birth: ____/____/____ Referred by: _____

Person to Contact in Emergency _____ Phone: () _____

INSURED/RESPONSIBLE PARTY INFORMATION

Full Name of Insured: _____ Relationship _____

Home Address (if different from above): _____ City: _____ Zip: _____

Employer: _____ Date of Birth: ____/____/____

Insured's ID#: _____ Group #: _____ Plan Name _____

Insurance Co.: _____ Phone: () _____

Is there secondary insurance? Yes No. If yes, please provide secondary insurance information.

Full Name of Insured: _____ Relationship _____

Home Address (if different from above): _____ City: _____ Zip: _____

Employer: _____ Date of Birth: ____/____/____

Insured's ID#: _____ Group #: _____

Insurance Co.: _____ Phone: () _____

1. I authorize use of this form or its contents on all of my insurance submissions.
2. I authorize the release of information to my insurance company.
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I hereby permit a copy of this to be used in place of the original.
5. I authorize payment of medical benefits to Lois Dennett for counseling services.
6. I acknowledge that I have read, understood, and agreed to abide by all of the office policies and information listed in the disclosure statement. I acknowledge that I have received a copy of these policies and information.
7. I acknowledge that I have received a copy of the Notice of Privacy Policies.

Signature _____

Date: _____

Signature _____

Date: _____

Signature _____

Date: _____

What concerns brought you here today? _____

What do you want to see happen as a result of coming here? _____

What have you tried on your own to solve your concerns? _____

Healthy Habit Information (please base your answers on the past month):

Have you participated in regular exercise / sports / recreation (about 3 times / week) to keep fit? Yes
No

Have you been directed to lose weight? Yes No

Have you smoked cigarettes on a daily basis? Yes No

How often in the past month did you drink alcohol? (Circle your answer)

- A) I do not drink at all B) About once a month C) 2 to 3 times a month D) 2 to 3 times a week
E) Once a day or more. Approximate number of drinks when drinking: _____

Have you used any drugs or medications not prescribed to you? Yes No If yes, which ones _____

What stressors are present in your life? Financial concerns; Medical concerns; Unemployment; Underemployment; Work related issues; Marital; Family; Other: _____

Family/Household Composition

Please list everyone who lives with you and their relationship to you (e.g. Spouse, Partner, Roommate, Daughter, Step-son, Mother, Father, etc.)

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth (children)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has there ever been an act of violence between any members of your household? Yes No

If yes, please give detail:

