REGISTRATION FORM

Office Use Only:

Therapist: _____

Dx: _____

This Google Form is HIPPA compliant through Google's Business Associate Addendum

* Indicates required question

1. Date *

Example: January 7, 2019

PERSONAL SECTION

2. First Name *

3. Last Name *

4. NAME OF PARENT/GUARDIAN (if under 18 years):

5. Street *

6. Address line 2

7. City *

8. State *

9. Country *

10. Zip Code *

11. Phone

12. Email** *

13. Age *

14. Gender *

15. Marital Status

Mark only one oval.

- Married
- Divorced
- Separated
- Widow
- Other

16. Domestic Partnership/Civil Union

Mark only one oval.

- Yes
- No

17. Children

Mark only one oval.

- Yes
- No

18. Children (Please List)

EMERGENCY CONTACT

19. First Name

20. Last Name

21. Phone Number

22. Relationship

USING AN EAP BENEFIT?

(if yes, please provide name & authorization #, etc.)

23. Are Using An EAP Benefit

Mark only one oval.

- Yes
- No

24. Insurance Name

_____

25. Identification Number

_____

26. Group Number

_____

27. RESPONSIBLE PARTY NAME (if other than self)

_____

28. **REFERRED BY**

_____

29. May we contact them?

Mark only one oval.

- Yes
- No

30. If yes, please provide their contact information

REGISTRATION FORM - Employment Section

Our Registration Form Is In Three Sections, (General, Employment, Health). Please Complete And Submit Each Section

31. Are You Employed

Mark only one oval.

- Yes
- No

32. If Yes, What Is Your Current Employment Situation?

Mark only one oval.

- Full Time
- Part-time
- Unemployed
- On Disability
- Minor/Not Employed

33. EMPLOYER NAME

34. JOB TITLE

35. IF A STUDENT

Mark only one oval.

- Full-time
- Part-time

36. SCHOOL/COLLEGE - NAME

37. DO YOU ENJOY YOUR WORK/SCHOOL

Mark only one oval.

- Yes
- No

38. Is There Anything Stressful About Your Current Work/School? (Please explain)

REGISTRATION FORM - Health & Mental Health

Our Registration Form Is In Three Sections, (General, Employment, Health). Please Complete And Submit Each Section

39. Primary Care Physician (PCP) Name

40. PCP Phone Number

41. PCP TREATMENT UPDATE (I would like for my PCP to be occasionally informed about my treatment?)

Mark only one oval.

- Yes
- No

42. Have You Previously Received Any Type Of Mental Health Services. (psychotherapy, psychiatric? services, etc.)?

Mark only one oval.

- Yes
- No

43. NAME OF THERAPIST(S)

_____

44. * Have you ever been prescribed psychiatric medication?

Mark only one oval.

- Yes
- No

45. * Please List And Provide Dates?

_____

_____

_____

_____

_____

46. How Would You Rate Your Current Physical Health? (Please Choose)

Mark only one oval.

- Poor
- Unsatisfactory
- Satisfactory
- Good
- Very good

47. * Please List Any Specific Health Problems You Are Currently Experiencing

48. How Would You Rate Your Current Sleeping Habits? (Please Choose)

Mark only one oval.

- Poor
- Unsatisfactory
- Satisfactory
- Good
- Very good

49. * Please list any specific sleep problems you are currently experiencing

50. How Many Times Per Week Do You Generally Exercise?

51. * What types of exercise do you participate in?

52. Please list any difficulties you experience with your appetite or eating patterns

53. Are you currently experiencing overwhelming sadness, grief or depression?

Mark only one oval.

- Yes
- No

54. * If yes, for approximately how long?

_____

55. Are you currently experiencing anxiety, panic attacks or have any phobias?

Mark only one oval.

- ◯ Yes
- ◯ No

56. * If yes, when did you begin experiencing this?

_____

57. Are you currently experiencing any chronic pain?

Mark only one oval.

- ◯ Yes
- ◯ No

58. * If yes, please describe

_____

_____

_____

_____

_____

59. Do you drink alcohol more than once a week?

Mark only one oval.

- Yes
- No

60. How often do you engage in recreational drug use?

Mark only one oval.

- Daily
- Weekly
- Monthly
- Infrequently
- Never

61. Are you currently taking any prescription medication?

Mark only one oval.

- Yes
- No

62. * Please list

63. Do you have any allergies?

Mark only one oval.

- Yes
- No

64. Are you currently in a romantic relationship?

Mark only one oval.

- Yes
- No

65. * If yes, for how long?

66. * On a scale of 1-10, how would you rate your relationship?

Mark only one oval.

- 1
- 2
- 3
- 4
- 5
- Option 6
- Option 7
- Option 8
- Option 9
- Option 10

67. What significant life changes or stressful events have you experienced recently

REGISTRATION FORM - Family History

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you, (father, grandmother, uncle, etc.). Please Complete Each Section

68. *Alcohol/Substance Abuse

Mark only one oval.

- Yes
- No

69. **If yes, list family member's relationship

70. *Anxiety

Mark only one oval.

- Yes
- No

71. **If yes, list family member's relationship

72. *Depression

Mark only one oval.

- Yes
- No

73. **If yes, list family member's relationship

74. *Domestic Violence

Mark only one oval.

- Yes
- No

75. **If yes, list family member's relationship

76. *Eating Disorders

Mark only one oval.

- Yes
- No

77. **If yes, list family member's relationship

_____

_____

_____

_____

_____

78. *Obesity

Mark only one oval.

- Yes
- No

79. **If yes, list family member's relationship

_____

_____

_____

_____

_____

80. *Obsessive Compulsive Behavior

Mark only one oval.

- Yes
- No

81. **If yes, list family member's relationship

82. *Schizophrenia

Mark only one oval.

- Yes
- No

83. **If yes, list family member's relationship

84. *Suicide Attempts

Mark only one oval.

- Yes
- No

85. **If yes, list family member's relationship

ADDITIONAL INFORMATION

86. Do You Consider Yourself Spiritual or Religious?

Mark only one oval.

- Yes
- No

87. * If yes, describe your faith or belief

88. What do you consider to be some of your strengths?

89. What do you consider to be some of your weakness?

90. What would you like to accomplish out of your time in therapy?

SIGNATURE

(By typing your name, you are consenting to using that as your electronic signature)

91. Your Signature *

92. Relationship To Patient *

93. Date *

Example: January 7, 2019

94. Math CAPTCHA: 8 + 17 = *