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Licensed Clinical Psychologist
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Richmond, Virginia 23227
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Adult Registration Form

All Information will be treated confidentially

Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Numbers: Home: _____ Cell: _____ Work: _____

SS# _____ Age: _____ Birth Date: _____ Marital Status: _____ Gender ____

Occupation: _____ Highest Education Level: _____

Employer: _____ Who referred you to me? _____

In Emergency, notify: _____ Phone Number: _____

Physician's Name and number: _____

Date of last Doctor's visit: _____ Purpose: _____

Current or Chronic Illnesses: _____ General Health: Good Fair Poor

Current Medications: _____

<u>If you want to use your insurance, this information needs to be complete and accurate.</u>

Subscriber's Name: _____ Date of Birth: _____

Employer: _____ Subscriber ID # _____ Your ID Number: _____

Primary Insurance Company: _____

Secondary Insurance: _____ ID# _____

Subscriber's Name: _____ Date of Birth: _____

<u>If you have received Mental Health services or treatment in the past:</u>

Name of Therapist: _____ Dates of treatment: _____

Major reason for seeking help at this time:_____

_____

Please add any other information you feel might be helpful: _____

_____

Please check ☑ any of the following concerns that pertain to you: (Use "other" below if this checklist does not apply to you)

☐ Academic concerns	☐ Finances	☐ Memory	☐ Sexual assault
☐ Alcohol use	☐ Friends	☐ Moodiness	☐ Sexual identity
☐ Anger control	☐ Gender issues	☐ Motivation	☐ Sexual problems
☐ Appetite	☐ General anxiety	☐ My thoughts	☐ Shyness
☐ Assertiveness	☐ GLBTQ issues	☐ Need for approval	☐ Sleep problems
☐ Career choice	☐ Grief/Loss	☐ Nightmares	☐ Social anxiety
☐ Concentration	☐ Guilt	☐ Parents	☐ Spirituality
☐ Conflict	☐ Harassment	☐ Perfection	☐ Stress issues
☐ Depression	☐ Headaches	☐ Physical fights	☐ Study skills
☐ Digestive troubles	☐ Health problems	☐ Procrastination	☐ Suicidal thoughts
☐ Drug use	☐ Homesickness	☐ Racial issues	☐ Test anxiety
☐ Eating behavior	☐ Hyperactivity	☐ Relationships	☐ Trauma
☐ Family stress	☐ Identity concerns	☐ Roommate problems	☐ Trust issues
☐ Fatigue	☐ Inferiority feelings	☐ School work	☐ Unhappiness
☐ Fears	☐ Legal matters	☐ Selecting major	☐ Victim of crime
☐ Feeling helpless	☐ Loneliness	☐ Self-control	☐ Violent thoughts
☐ Feeling hopeless	☐ Making decisions	☐ Separation issues	☐ Work issues

Other concerns:

_____

_____

<u>Medical History:</u>

Appetite Disturbance _____ Sleep Disturbance _____ Seizures _____ Allergies _____

Head Trauma _____ Other _____ Hospitalizations _____

Name 2 specific goals you would like to work on in counseling:

(1)_____

(2)_____

Members of your immediate family:

Name(s)	Age	Relationship	Occupation

Please describe any difficulties that have been present in your family of origin or extended family, such as learning difficulties, alcoholism, violence, mental health problems, etc. _____

_____

_____

Any other information that would be relevant for your treatment or that you would like me to know_____

_____

_____

Note: Initial and ongoing treatment sessions are 45 minutes. The fee for all sessions is $100. Payment is requested at the time services are rendered. If you wish to make other arrangements, please discuss them with me at our first appointment.

Date: _____ Signature of Person Responsible for Payment _____