

Integrative Psychological and Assessment Services

Client Registration Form

Please complete this form as fully as possible. *This information is **confidential** and for our use only and will **not** be released to any person or group without your written consent. Please print clearly.*

Client Information

<hr/> <i>Client's Name</i>	<hr/> <i>Date of Birth</i>	<hr/> <i>Age</i>
<hr/> <i>Home Address: street, Apt.#</i>	<hr/> <i>City, Zip Code</i>	<hr/> <i>If under 18yrs, name of Guardian</i>
<hr/> <i>Home Telephone #</i>	<hr/> <i>Work Telephone #</i>	
<hr/> <i>Cellular Phone #</i>	<hr/> <i>Best # to leave message?</i>	<hr/> <i>Email</i>
<hr/> <i>Name of Emergency Contact</i>	<hr/> <i>Telephone #</i>	<hr/> <i>Relationship</i>
<hr/> <i>Name of Referring Person</i>		

Briefly describe the concern or situation that brought you in today: _____

Responsible Party Information (If different from above)

<hr/> <i>Name of Responsible Party</i>	<hr/> <i>Date of Birth</i>	<hr/> <i>Social Security No.</i>
<hr/> <i>Address: street, Apt.#, city, state, zip</i>		<hr/> <i>Phone #</i>
<hr/> <i>Insurance Carrier</i>	<hr/> <i>ID#</i>	<hr/> <i>Group #</i>
<hr/> <i>Place of Employment</i>		<hr/> <i>Work #</i>
<hr/> <i>Address of Employer</i>		<hr/> <i>Length of current employment</i>

Please put a check next to the services you would like continued information on:

- | | |
|--|---|
| <input type="checkbox"/> ADHD support groups | <input type="checkbox"/> Programs for Parents and Youth |
| <input type="checkbox"/> Programs for Adults | <input type="checkbox"/> ADHD, Learning Disability, or psychological assessments. |
-

Confidential

Family Information

Number of people in the client’s current household: _____ Marital Status of Client: Single Married Committed
 Separated Divorced Widowed

Languages spoken if other than English: _____ Religious preference (Optional): _____

Please list client’s immediate family including adult children and those not living with the client.

Names	Sex	Birthdate	Relationship	At Home

Educational/ Occupational Information

Is the client currently a student? ___ YES ___ NO Name of last school attended: _____

Highest grade completed: _____ Highest degree and major: _____

Does the client have any learning difficulties? ___ YES ___ NO If yes, please briefly describe: _____

Is the client currently: ___ Employed ___ Unemployed ___ Retired ___ Other (please specify): _____

Occupation: _____

Health Information

Name of client’s primary care physician _____

Physician’s telephone number _____

Is the client currently under at doctor’s care? ___ YES ___ NO If yes, for what reason? _____

List current medications client is taking:

Medication	Dosage	Prescribed by/For what reason?

Has the client received past counseling or psychotherapy? ___ YES ___ NO If yes, whom did the client see?

Whom did the client see?	Dates	For what reason?

Has the client received other health care services? ____ YES ____ NO If yes, whom did the client see?

Whom did the client see?	Dates	For what reason?

Payment Authorization

I understand that it is my responsibility to pay for the fee established for professional services rendered to the above client. I hereby authorize payment of benefits directly to Christina Zampitella, Psychologist PC

Date

Signature