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Client registration Form

Name: ____________________

Address: (street)____________________

(city & state) ____________________ (zip)____________________

Date of Birth: ____________________

Telephone: Home: ____________________ Work: ____________________ Cell: ____________________

Emergency Contact: Name____________________ Phone: ____________________

Relationship to you____________________

Restrictions on leaving messages for you: ____________________

Referred By: ____________________

If I can thank your referral source, please sign here: ____________________

insurance information

Insurance company: ____________________

ID#(s): ____________________ Group#: ____________________

Subscriber (if other than client): ____________________

Subscriber's date of birth: ____________________ Relationship to insured: ____________________

Subscriber's place of employment: ____________________

FOR YOUR BENEFIT, PLEASE CONTACT YOUR INSURANCE COMPANY TO DETERMINE THE MENTAL HEALTH COVERAGE AVAILABLE TO YOU.

I give permission for Rena Mei-Tal, Psy.D. to 1) request information from and provide information to my insurance company, and 2) allow a photocopy of my signature to be used for the purpose of filing insurance claims. ***I understand that I am fully responsible for complete payment of all services rendered and I accept that responsibility.***

____

Client Signature Date

Please provide a brief summary of the reasons for which you are seeking services:

___

Please check any of the following that constitute a problem for you:

___Nervousness
___Shyness
___Separation
___Drug Use
___Anger
___Sleep
___Relaxation
___Legal Matters
___Energy
___Loneliness
___Nightmares
___Appetite

___Depression
___Sexuality
___Alcohol Use
___Self Control
___Stress
___Relationship Issues
___Parenting Problems
___Fears
___Weight Concerns
___Career/Work Issues
___Family of Origin Issues
___Moral Dilemmas

___Suicidal Thoughts
___Friends/Friendships
___Finances
___Unhappiness/Dissatisfaction
___Spiritual Issues
___Existential Issues
___Health Problems
___Disturbing Thoughts
___Abuse/Neglect
___Grief/Loss
___Trauma
___Compulsive Behaviors

Please provide the name, address and telephone number of your primary care physician:

___

When were you last examined by a physician?

List any major health problems for which you are currently receiving treatment:

___

Please list ALL medications that you are currently taking:

___

Please identify any allergies you may have:

___

Please list any previous hospitalizations (medical or psychiatric) including hospital name, dates and reasons for hospitalization:

___

Please note any relevant family medical/psychiatric history:

___

Please identify any substances (alcohol, cigarettes, supplements, non-prescription medications, etc.) you are currently using or have used in the past:

___

All information contained in this Client Registration Form is the property of Rena Mei-Tal, Psy.D., ABPP. This information is confidential and will not be shared with anyone unless authorized by you in writing, subject to state and federal law.