Stephens Psychological Services
drcarolsunvalley@gmail.com

CLIENT REGISTRATION

Name ____ Today's Date________________

Address ____ Date of Birth________________

City____ State______________ Zip_______

Phone #s _________________________ ____
Home *Work* *Cell*

Referral Source______________________________ Social Security Number_________________

Insurance Provider_____________________________ Policy # ______________________________

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Please provide a photocopy of both sides of your insurance cards, and find out your mental health benefits are for your policy. If prior authorization is needed, let me know that, before the first appointment.

Occupation_____________________________________ Highest Degree Completed________

Emergency Contact_______________________ _________________________________
Name *Relationship to you*

Phone #s ____

Ethnic Identity ____

Religion/Spiritual Practice ____

Current Relationship Status ____
Single *Partnered* *Married* *Separated* *Divorced* *Widowed*

Names/Ages of Partner/Children/Pets ____
____
____

Medical Concerns / Health Information ____
____
____

Medications____
____

Alcohol/Other Chemical Use/Abuse/Treatment
____
____

Previous Therapy or Treatment ____
____
____
____

Reason for Seeking Therapy/Goals for Therapy (can use back)
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