Shore Counseling and Consulting Clinic

* INITIAL REGISTRATION PACKET *

THERAPIST: _____ DATE OF FIRST VISIT: _____

LOCATION: ☐ MAYFAIR ☐ WALKER'S POINT ☐ GLENDALE

▪ GENERAL DEMOGRAPHIC INFORMATION ▪

CLIENT INFORMATION:

CLIENT LAST NAME:		FIRST NAME:		MI:
DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	SEX:	RACE:	ETHNICITY:
CLIENT ADDRESS: STREET		CITY:	STATE:	ZIP:
HOME PHONE:	CELL PHONE:	MARITAL STATUS: (CIRCLE) **S M SEP DIV WID**		
EMAIL ADDRESS:		WOULD YOU LIKE TO RECEIVE ELECTRONIC STATEMENTS AND BE ABLE TO MAKE PAYMENTS ONLINE? (CIRCLE) **Yes No**		
EMPLOYER:	WORK PHONE:	MAY WE CALL YOU AT WORK? (CIRCLE) **Yes No** MAY WE LEAVE A MESSAGE AT WORK? (CIRCLE) **Yes No**		
EMPLOYER ADDRESS: STREET		CITY:	STATE:	ZIP:
REFERRED BY: (IF APPLICABLE)	REASON FOR REFERRAL:			

***PRIMARY EMERGENCY CONTACT:** (NAME/PHONE NUMBER) _____

PRIMARY INSURANCE:

INSURANCE NAME		INSURANCE CO. ADDRESS: STREET	CITY:
STATE:	ZIP:	INSURANCE CO. PHONE:	EFFECTIVE DATE:
SUBSCRIBER NAME:		SUBSCRIBER EMPLOYER:	SS#:
RELATIONSHIP TO PATIENT:		MEMBER ID:	GROUP #: (IF APPLICABLE)

SECONDARY INSURANCE: (IF APPLICABLE)

INSURANCE NAME		INSURANCE CO. ADDRESS: STREET	CITY:
STATE:	ZIP:	INSURANCE CO. PHONE:	EFFECTIVE DATE:
SUBSCRIBER NAME:		SUBSCRIBER EMPLOYER:	SS#:
RELATIONSHIP TO PATIENT:		MEMBER ID:	GROUP #: (IF APPLICABLE)

Shore Counseling and Consulting Clinic

▪ FAMILY & MEDICAL HISTORY ▪

FAMILY MEMBERS:

LAST NAME	FIRST NAME	DATE OF BIRTH	RELATIONSHIP	PHONE NUMBER (IN CASE OF EMERGENCY ONLY)
1.				
2.				
3.				
4.				

MEDICAL INFORMATION:

PRIMARY PHYSICIAN:	DATE OF LAST EXAM:
PRIMARY PSYCHIATRIST (IF APPLICABLE):	DATE OF LAST APPOINTMENT:

NOTE: A RELEASE OF INFORMATION MAY BE REQUESTED AS PART OF YOUR ONGOING PLAN OF CARE.

LIST ANY CURRENT/PREVIOUS MEDICATIONS AND DOSAGES:

_____

_____

_____

_____

_____

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING CONDITIONS? (CHECK ANY THAT APPLY)

- ☐ Allergies
- ☐ Chronic Fatigue
- ☐ Hay Fever
- ☐ Asthma
- ☐ Emphysema
- ☐ Skin Problems
- ☐ Constipation
- ☐ Birth Control Problems
- ☐ Irritable Bowel
- ☐ Stomach Problems
- ☐ PMS
- ☐ Other Condition(s):

- ☐ Blood Disease
- ☐ Chronic Pain
- ☐ Cancer
- ☐ Diabetes
- ☐ Low Blood Sugar
- ☐ Thyroid Problems
- ☐ Liver Disease
- ☐ Sexually Transmitted Disease (STD)
- ☐ Vision Problems
- ☐ Speech Problems
- ☐ Weight Problems

- ☐ Blood Pressure
- ☐ Arthritis
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Bladder Problems
- ☐ Prostate Disease
- ☐ Menstrual Problems
- ☐ Abortion/Miscarriage
- ☐ Sexual Problems
- ☐ Sleep Problems
- ☐ Dental Problems

- ☐ Back Trouble
- ☐ Fibromyalgia
- ☐ Head Injury
- ☐ Infertility
- ☐ Headaches
- ☐ Injury/Fracture
- ☐ Epilepsy/Seizures
- ☐ Eating Disorder
- ☐ Drinking Problems
- ☐ Drug Abuse
- ☐ Hearing Problems

_____

_____

_____

▪ FAMILY & MEDICAL HISTORY (CONTINUED) ▪

PLEASE LIST ALL PRIOR MENTAL HEALTH SERVICES RECEIVED:

WITH WHOM?	**HOW LONG?** (IF POSSIBLE, SPECIFY DATES)	**SERVICE(S) RECEIVED?**

PLEASE INDICATE ANY FAMILY HISTORY OF MEDICAL OR PSYCHOLOGICAL CONCERNS:
(PLEASE INCLUDE ANY PHYSICAL/EMOTIONAL PROBLEMS, HISTORY OF ALCOHOL/SUBSTANCE ABUSE, CHILDHOOD ABUSE HISTORY, OR OTHER SIGNIFICANT EVENTS/CONDITIONS)

▪ PRESENTING ISSUES ▪

CURRENT AREAS OF CONCERN: (PLEASE CHECK ANY AREA WHERE YOU THINK YOU MAY NEED THERAPEUTIC SUPPORT)

- ☐ Depression
- ☐ School Concerns
- ☐ Frequent Mood Changes
- ☐ Marital Problems
- ☐ Tiredness/Fatigue
- ☐ PMS
- ☐ Suicidal Thoughts
- ☐ Learning Difficulties
- ☐ Drinking Problems
- ☐ Anxiety/Nervousness
- ☐ Work/Career Problems
- ☐ Issues from Childhood
- ☐ Parenting Skills
- ☐ Sleep Disturbances
- ☐ Weight Loss/Gain
- ☐ Suicide Attempt
- ☐ Pain
- ☐ Drug Problems
- ☐ Interpersonal Relationships
- ☐ Panic Attacks
- ☐ Memory/Concentration
- ☐ Guilt
- ☐ History of Emotional Abuse
- ☐ Eating/Appetite Change
- ☐ Exercise/Hobbies
- ☐ Legal (Lawsuit/Charges)
- ☐ Trauma
- ☐ Anger/Temper
- ☐ Phobias
- ☐ Isolation/Withdrawal
- ☐ Low Self-Esteem
- ☐ Sexual Dysfunction
- ☐ Menopause Issues
- ☐ Indecision
- ☐ Gambling Problems
- ☐ Nicotine/Smoking Problems
- ☐ Other:

PLEASE INDICATE ANY OTHER INFORMATION THAT MAY ASSIST IN YOUR TREATMENT: