Adria O'Donnell, Psy.D. PSY19207

Clinical and Consulting Psychology

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CLIENT REGISTRATION: ADULT FORM

1. Personal Information **Today's Date:_____**

Full Name: _____ Date of Birth:_____ Age:_____

Address:_____ City: _____

State: _____ Zip: _____ Martial Status: _____

Home: (____)_____ Work: ____)_____Cell: (___)_____

e-mail: _____ Religious Affiliation:_____

Emergency Contact Information

Name: _____ Relationship:_____

Address:_____ City: _____ State: _____ Zip: _____

Home Phone: (____)_____ Work: (____)_____ Cell/Mobile:(____)_____

2. Responsible Party Information

Name of Responsible Party: _____

Address (if different than client's)_____

Relationship:_____ Birth Date: _____

Place of Employment: _____ Length of Employment: _____

Home: (____)_____ Work: (_____)_____ Cell: (_____)_____

3. Highest Level of Education Completed: (circle one) Some High School High School/ GED

Some College Technical/Apprentice Certification Associates Degree BA/BS degree

Some graduate MA/MS degree MD/JD/Doctoral Degree

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 directly to Adria O'Donnell, Psy.D. In addition, **24 hours** notice is required to cancel an appt. in order to avoid late charges.

Signature of Responsibly Party _____ Date: _____

4. Employment Information

Employment Status (circle) Full Time Part-time Student Unemployed

Job Title:_____ Employer:_____

5. Current Living Situation

Please fill in the chart below, including everyone who currently lives in your home.

First Name	Age	Relation to You	Occupation

6. Personal Background: Please circle and fill in Blanks

Parents:

Father Living If alive, age?_____ Occupation _____

Deceased If deceased, age at time of death _____ Cause of Death: _____

Mother Living If alive, age?_____ Occupation _____

Deceased If deceased, age at time of death _____ Cause of Death: _____

Occupation _____

Sibling: Living If alive, age?_____ Occupation _____

Deceased If deceased, age at time of death _____ Cause of Death: _____

Where were you born? _____

Where have you lived? _____

Did you have frequent moves? YES NO If so, briefly describe _____

_____

_____

7. Health History

Please list any serious illnesses that you *currently* have (i.e.: diabetes, hypertension): _____

_____

_____

Please describe any medical issues you have had in the past. Include all major surgeries:_____

_____

_____

Please list any medication that you *currently* take (prescribed or over the counter.

Medication Name	**Dosage**	**Reason for Medication**

Prescribing Doctor: _____

*Doctor's Contact Information:_____

*(Collaboration among professionals working with you will assist in your care. A signed Authorization form will be requested to consult with this professional.)

8. Psychological History

Are you currently seeing a counselor/therapist? YES NO If so, name of therapist _____

Have you ever been in therapy before? YES NO If so, was it helpful? YES NO

Why did you stop treatment with this person: _____

If so, briefly describe the issues of your previous counseling _____

_____

_____

Previous Hospitalizations YES NO
If so, when: _____ Where:_____ Duration: _____

9. Current Situation

Please briefly describe the reasons for seeking help at this time:_____

_____

_____

_____

When did these issues arise? _____

Please describe some goals you hope to achieve in coming here: _____

_____

_____

_____