

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: Marital 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

☐ 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 Responsible Party

Date

4 Employment Information

Employment Status:

☐ 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 check and fill in blanks.

Father☐ Living ☐ Deceased

If alive, age?

Occupation:

If deceased, age at time of death:

Cause of Death:

Mother☐ Living ☐ Deceased

If alive, age?

Occupation:

If deceased, age at time of death:

Cause of Death:

Sibling☐ Living ☐ Deceased

If alive, age?

Occupation:

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: