

**Client Registration and Information Form
THE INTEGRAL PSYCHOLOGY CENTER**

Name: _____ Date: _____

PEOPLE YOU PRESENTLY LIVE WITH

Name _____ Relationship _____ Age _____ Occupation _____

MARITAL HISTORY

Name _____ Year Married _____ # of children _____ Reason if Separated _____

EDUCATIONAL HISTORY

Highest Grade Completed: _____ Degrees: _____

Other Education: _____ Any difficulties? ___Y ___N

PHYSICAL HEALTH

Name of Physician: _____ Date of Last Physical: _____

Do you take any prescribed medication?: ___Y ___N Please

list: _____

Any major health problems or physical/sensory disabilities? ___Y ___N List: _____

Do you exercise regularly? ___Y ___N If so, what? _____

Do you use: Caffeine? ___Y ___N Alcohol? ___Y ___N Tobacco? ___Y ___N

MENTAL HEALTH HISTORY

If you or a family member have been to a therapist before, please indicate who, when and why: _____

In your family, has there ever been an incident of:

Suicide or suicide attempts? ___Y ___N

Incest or sexual molestation? ___Y ___N

Child abuse? ___Y ___N

Serious harm to or by another person? ___Y ___N

Major life changes within the past year? ___Y ___N

Cont.

PLEASE CHECK THE FOLLOWING ITEMS THAT ARE OF CONCERN TO YOU:

- Depression
- Mood Swings
- Suicidal Feelings or Thoughts
- Anxiety, Fears, Worries
- Irritable, Angry, Hostile Feelings
- Self- Esteem
- Loneliness
- Lack of Assertiveness/ Shyness
- Eating/Weight Problems
- Alcohol and/or Drugs
- Smoking
- Loss of a Significant Person
- Physical Symptoms (e.g., headaches, pain)
- Compulsive Behavior
- Romantic Relationship
- Sexual Matters
- Family Problems
- Conflict with Others
- Gay/Lesbian Issues
- Pregnancy
- Career/Work Issues
- Chronic of Life Threatening Condition
- Emotional, Physical or Sexual Abuse
- Other Loss or Change

Other (please specify): _____
=====

PLEASE COMPLETE THE FOLLOWING:

The reason I am seeking therapy now is: _____

What I want most from my therapist is: _____

I will know my therapy has been successful when: _____

Other things that my therapist should be aware of are: _____

—

If we need to confirm or cancel an appointment, may we telephone you at home? ___Y ___N At work?
___Y ___N

For billing purposes, may we mail bills or statement to your home? ___Y ___N *If the answer is "No,"
please let your therapist or the Office Manager know.*

Signature of person completing form will be taken in person

Signature of parent?guardian will be taken in person