

Stephens Psychological Services
sps@hushmail.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 #s _____

Please provide a photocopy of both sides of your insurance cards, and find out what 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)

