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_____

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)
_____
_____
_____

I am not a provider for Medicare or insurance networks at this time. Please sign and date that you agree to pay directly for my service and that you will not submit this bill to Medicare because Medicare does not accept bills from non-participating providers.

Name_____ **Date**_____