Client Registration & Information Form

THE INTEGRAL PSYCHOLOGY CENTER, INC.

Name: _____ Date: _____

Preferred Pronouns: _____ Date of Birth:_____

Therapist you are scheduled to meet with:_____

PEOPLE YOU PRESENTLY LIVE WITH:

Name	Relationship	Age	Occupation

PARTNERSHIP / MARITAL HISTORY:

Name	Year Married	Present Status	#of Children

EDUCATIONAL HISTORY:

Highest Grade Completed: _____ Degrees: _____

Other Education: _____ Any Difficulties? Y_____ N _____

OCCUPATIONAL HISTORY:

Present Occupation: _____ How Long?: _____

Present Employer: _____ Any Difficulties? Y_____ N _____

PHYSICAL HEALTH:

Name of Physician: _____ Date of Last Physical: _____

Please list prescribed medications & reason for taking: _____

_____

Do you have any major health problems or physical/sensory disabilities? Y_____ N _____

Description_____

Do you exercise regularly? Y_____ N _____ If yes, what?_____

Do you use:

Caffeine	Y_____	N _____	Amount _____	Frequency _____
Alcohol	Y_____	N _____	Amount _____	Frequency _____
Tobacco	Y_____	N _____	Amount _____	Frequency _____

Do you have a history of substance abuse treatment? Y_____ N _____

PLEASE TURN PAGE OVER TO COMPLETE THIS FORM

MENTAL HEALTH HISTORY:

Have you ever been to a therapist or counselor before? _____

Please list who, when and why: _____

_____

If you take medications for your mental health, please list name of prescriber, contact information and date of last visit_____

_____

PLEASE CIRCLE Y OR N:

Have **YOU** ever had an incident of:			In **YOUR FAMILY**, has there ever been:		
Self-Harm	Y	N	Self-Harm	Y	N
Suicide Attempt	Y	N	Suicide Attempt	Y	N
Incest/Sexual Molestation	Y	N	Incest/Sexual Molestation	Y	N
Child Abuse	Y	N	Child Abuse	Y	N
Physical Violence	Y	N	Physical Violence	Y	N
Major Life Changes within the past year	Y	N	Major Life Changes within the past year	Y	N
Hospitalization	Y	N	Hospitalization	Y	N
Mental Health Treatment	Y	N	Mental Health Treatment	Y	N

PLEASE CIRCLE THE FOLLOWING ITEMS THAT ARE RELEVANT 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/Body Image
Alcohol and/or Drugs
Smoking
Loss of a Significant Person
Physical Symptoms (Headache, Pain, etc)
Compulsive Behavior
Romantic Relationship
Sexual Matters/Sexual Health
Gender Identity
Family Problems
Conflict with Others
LGBTQIA
Career/Work Issues
Chronic or Life Threatening Illness
Emotional, Physical, or Sexual Abuse
Traumatic Experience

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 my therapist should be aware of are: _____

If we need to confirm or cancel an appointment, may we telephone you at home? _____ at work? _____
For billing purposes, may we mail bills or statements to your home? _____
If the answer to any of these contact questions is "no", please let your therapist or the Office Manager know.

Signature of Person Completing Form: _____

Signature of Parent or Guardian: _____