Account # _____

Shirley Leech, Ph.D.
Clinical Psychologist

CLIENT REGISTRATION FORM

Please print clearly!

Client _____
last name first m.i.

Residence _____
street city state zip

Employer (or School) _____
street city state zip

S.S. # _____
Birth date _____
Age _____
(H) Phone _____
(W) Phone _____
(M) Phone _____
Email _____

Yrs of Education _____ Highest Degree _____ School _____ Yr. Grad. _____

Occupation _____ Marital Status _____ Spouse's Name _____

Spouse's Occupation _____ Employer _____ (W)Phone _____

# of Children _____ Names & ages _____ Referred by _____

Emergency Contact _____
name street city state zip phone

Parent/Guardian _____
name street city state zip phone

Primary Health Insurance _____
name street city state zip

Phone # _____ Name of insured _____ Group # _____ S.S. # _____

Second Health Insurance _____
name street city state zip

Phone # _____ Name of insured _____ Group # _____ S.S. # _____

Permission is given the provider to verify my insurance coverage: YES NO

_____
Signature of the Insured Date

I agree that I ultimately am responsible for paying for all services rendered, and, if I fail to do so, I agree to pay court costs and attorney's fees incurred in the collection of the client account. If the treatment is monitored by a managed care agency, my financial liability is limited by the terms of the provider's contract with the managed care agency.

_____
Signature of Person Responsible for Account Date

MENTAL HEALTH TREATMENT No Treatment History _____

	Age	Inpatient/Outpatient	Approx. Dates	Name of Therapist/Agency
1st Episode				
2nd Episode				
3rd Episode				
4th Episode				
Latest Episode				

Briefly describe your response to treatment for each episode: _____

MEDICAL SELF REVIEW FORM

FAMILY HISTORY

Has any relative(including immediate family & both sides of family) had a history of:

	Yes	Who		Yes	Who
Alcoholism			Kidney Disease		
Cancer			Mental Illness		
Diabetes			Mental Retardation		
Epilepsy			Migraine		
Goiter			Physical Handicap		
Heart Disease			Tuberculosis		
			Other:		

PERSONAL HISTORY

Primary Care Physician _____ Address: _____

Date of Last Physical _____ Height: _____ Weight: _____

Mark with an (x) any condition(s) that you have *now* or had in the past:

	Now	Past		Now	Past		Now	Past
Genetic Defect			Prostate Disorder			Epilepsy/Seizures		
Severe Accident			Arthritis			Migraine		
Hi/Low Blood Pressure			Tumor/Malignancy			Tension Headaches		
Low Blood Sugar			Glaucoma			Fainting Spells		
Diabetes			Heart Disease			Multiple Sclerosis		
Anemia			Ulcer			Muscular Dystrophy		
Thyroid Disorder			Colitis/Crohn's Dis.			Lupus		
Skin Disorder			Hepatitis			Sickle Cell Anemia		
VD, Gonorrhea, etc			Asthma			Alcohol/Drug Addiction		
HIV &/or AIDS			Tuberculosis			Other:		
Kidney Disease			Bronchitis			Other:		
Bladder Disorder			Emphysema			Other:		

Please give details about any items checked, including approximate dates of treatment, name of doctor, your response to treatment: _____

List & give dates of any operations, injuries, or illness requiring hospitalization: _____

Medications you take or have taken in the last six months (prescription & non-prescription)

Name	Strength	Frequency	Date of 1st prescription	Date of latest prescription	Prescribing Physician

Do you have any allergies(medications, pollen, food, etc.)? _____ If "yes," please describe to what you are allergic, type of reaction, and treatment: _____

Please mark with a (x) if you have noticed any recent changes in your:

	Yes	No		Yes	No		Yes	No
Vision			Physical Strength			Hearing		
Balance			Ability to Think			Speech Pattern		
Memory			Eating Habits			Energy Level		
Sleep Pattern			Sexual Activity			Bowel Habits		
Menstrual Cycle			Motor Coordination			Bladder Habits		

Habit Forming/Addictive Substance Abuse

Type	Amount/Frequency	Date Began	Date Quit	If Treated, Where? When?
Alcohol				
Amphetamines				
Cocaine/Crack				
Heroin				
Inhalants (e.g. glue)				
LSD (acid) Peyote				
Marijuana (pot)				
Nicotine				
PCP, Angel Dust				
Prescription Drugs				
Over the Counter				
Other				

Comments: _____

Name: _____ Date: _____

Please check all the symptoms that fit your current situation:

_____ Anxiety
_____ Nervousness
_____ Restlessness
_____ Poor sleep
_____ Sleep too much
_____ Poor appetite
_____ Eat too much
_____ Depression
_____ Sadness
_____ Low motivation
_____ Low energy
_____ Cry a lot
_____ Feel empty

_____ Feelings of suspicion
_____ Feel you can read others' thoughts
_____ Hear or see things others' cannot
_____ Spend more money than you should
_____ Angry much of the time
_____ Suicidal
_____ Homicidal
_____ Explosive
_____ Easily frustrated
_____ Irritable
_____ Forgetful
_____ Persistent thoughts or preoccupations
_____ Repetitive behaviors

In your own words, describe why you have come here today.

How long have you been feeling this way?

INFORMED CONSENT

I_____agree to be seen by Shirley Leech, Ph. D for psychological evaluation and/or treatment. I understand that information shared with Dr. Leech will be kept in confidence except in the following situations:

-If I give my written permission for information to be shared with another person or agency.

-If Dr Leech or I have suspicions of neglect or abuse of a child, elderly, or handicapped person. These suspicions will be shared with the proper authorities as required by law.

-If I threaten to seriously hurt myself or other people, information will be shared to insure mine, yours, and others safety.

-If records are ordered to be released by court order or by Homeland Security.

-If my insurance company requests information regarding procedures and diagnosis necessary for billing purposes. I also understand that once the insurance company has this information, Dr. Leech has no control over who may have access to it.

I understand that I am responsible for paying the cost of these psychological services which are billed at $125.00 for the initial evaluation and at $110.00 per 50 minute treatment hour and that I am responsible for any co-payments, deductibles, and the balance not paid by my insurance.

I understand that I must give 24 hour notice of the cancellation or I will be billed for the hour I reserved.

_____ _____

Patient's Signature Date