

New Client Registration



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Licensed Psychologist

Today's Date: _____

(for office use) DSM IV : _____

Name: _____ Age: _____ Gender: _____

Address: _____ City/State: _____ Zip: _____

Date of Birth: _____ Relationship status: _____

Home Phone: (_____) _____ May I call you at this number? Y N Leave a message at this number? Y N

Cell Phone: (_____) _____ E-mail: _____

Person responsible for bill: _____ Relationship: _____ Phone: (_____) _____

Address: _____ City/State: _____ Zip: _____

Who referred you? _____ Phone: (_____) _____

Address: _____ City/State: _____ Zip: _____

Employer Information:

Employer: _____

Address: _____ City/State: _____ Zip: _____

Work Phone: (_____) _____ May I call you at this number? Y N Leave a message at this number? Y N

Occupation: _____ Current Position: _____ How long? _____

Insurance Information:

Primary Insurance Company: _____

Address: _____ City/State: _____ Zip: _____

Name of Insured: _____ Date of Birth: _____

Subscriber ID Number: _____ Group Number: _____

Secondary Insurance Company: _____

Address: _____ City/State: _____ Zip: _____

Name of Insured: _____ Date of Birth: _____

Subscriber ID Number: _____ Group Number: _____

In Case of Emergency, Notify:

Name: _____ Relationship: _____

Address: _____ City/State: _____ Zip: _____

Daytime Phone: (_____) _____ Evening Phone: (_____) _____

Household Information

Name	Age	Relationship	Occupation / Grade in School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Health

Physician: _____ Phone: (_____) _____

Address: _____

Date of last physical exam: _____ Please list **any** health problems: _____

List **all** medications you are now taking – prescription (including birth control pills) and nonprescription (such as aspirin, supplements etc):

Medication	Dosage (amount & times per day)	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Number of cigarettes per day: _____ Amount of caffeine per day: _____

Please describe typical use of alcohol (amount, frequency): _____

Do you or anyone else believe that your drinking is a problem? _____

Please describe typical exercise (type, amount, frequency): _____

What are your hobbies? _____

Family History

Please indicate any psychological or medical difficulties experienced by other members of your family:

Father: _____

Mother: _____

Sisters: _____

Brothers: _____

Aunts/Uncles: _____

Grandparents: _____

Children: _____

Current Symptoms

Please circle any of the following areas in which you are having difficulty:

- | | | | | |
|------------------|-------------------|------------------|---------------------|-------------------|
| Nervousness | Shyness | Weight Change | Drug Use | Communication |
| Anger | Inferiority | Sleep | Can't Relax | Motivation |
| Legal Matters | Energy | Loneliness | Lack of Interest | Fainting |
| Education | Dizziness | Hyperventilation | Bowel Troubles | Restlessness |
| Irritability | Isolation | Appetite Change | Depression | Hopelessness |
| Sexual Problems | Boredom | Alcohol Use | Fatigue | Impatience |
| Self-Control | Stress | Hearing Voices | Headaches | Overwhelmed |
| Memory | Pain | Self Esteem | Crying | Marriage |
| Career Choices | Hair Pulling | Panic | Eating Problems | Concentration |
| Shaky | Being a Parent | Paranoia | Mood Swings | Racing Heart |
| Fears | Suicidal Thoughts | Finances | Palpitations | Health Problems |
| Friends | Can't Have Fun | Nausea | Work | Avoid People |
| Perspiring | Dating Skills | Assertiveness | Stomach Problems | Compulsive Habits |
| Making Decisions | Perfectionism | Guilt | Repetitive Thoughts | |
| Violence | Skin Picking | Family | Other: _____ | |

Briefly describe your reasons for seeking help: _____

History

Have you ever seen a psychologist, psychiatrist or counselor before?

Dates	Names	Reasons	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe any major changes in your life in the past two years: _____

When did you last feel well? _____

Please add any additional information you feel would be useful: _____

For those clients who are using their health insurance to cover the costs of services, you should know that most companies require that this information be present in your treatment file. Although this information is confidential, should your insurance carrier request access to this information, they do have the right to review and copy it. Failure to have this information or to provide it to them could cause you to be ineligible for insurance coverage. The only way for you to be assured that your file is kept confidential is to choose not to use your insurance company and to pay out of pocket for services. Although this will cause you to incur some expense, it will maintain your privacy in the long run, and you must decide if the potential loss of privacy to an insurance company is worth the reduction in cost.