



IVY RUTHS, PH.D.  
LICENSED PSYCHOLOGIST

### Client Registration Information Form

Today's date: \_\_\_\_\_

#### Identification

Your name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_  
Nicknames or aliases: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Home street address: \_\_\_\_\_ Apt.: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
Home/evening phone: \_\_\_\_\_ e-mail: \_\_\_\_\_  
Calls or e-mail will be discreet, but please indicate any restrictions:  
\_\_\_\_\_

#### Referral: Who gave you my name to call?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

May I have your permission to thank this person for the referral?  Yes  No

How did this person explain how I might be of help to you? \_\_\_\_\_  
\_\_\_\_\_

#### Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_

Significant other/nearest friend or relative not residing with you: \_\_\_\_\_

#### Marital Status (circle one)

Single      In a relationship      Married      Separated      Divorced      Widowed

#### Student Status (circle one)      Full-Time      Part-Time      Nonstudent

Highest Degree Obtained: \_\_\_\_\_ Year: \_\_\_\_\_ Institution: \_\_\_\_\_



**Employment Status (circle one)**

Full-Time      Part-Time      Retired      Disabled      Unemployed

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Work phone: \_\_\_\_\_ or other means of communication \_\_\_\_\_

Calls will be discreet, but please indicate any restrictions: \_\_\_\_\_

Date last worked if unemployed: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

**Medical care**

Clinic/doctor's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment?  Yes  No

Psychiatrist's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

How long have you been working with this provider? \_\_\_\_\_ Frequency of sessions: \_\_\_\_\_

If you enter treatment with me for psychological problems, may I tell your psychiatrist so that he or she can be fully informed and we can coordinate your treatment?  Yes  No

Please list any current medications:

MEDICATION	DOSAGE	FREQUENCY	PRESCRIBED FOR:

**Medical Problems (Please list):**

PHYSICAL/MEDICAL CONDITIONS: \_\_\_\_\_

DRUG ALLERGIES: \_\_\_\_\_

FOOD ALLERGIES: \_\_\_\_\_

RECENT MEDICAL PROCEDURES OR HOSPITALIZATIONS: \_\_\_\_\_

\_\_\_\_\_





**Have you been in any intensive treatment programs or been hospitalized?**

<b>Reason for treatment</b>	<b>Dates of admission</b>	<b>With whom/Where</b>	<b>Outcome</b>

**Briefly describe what brings you to see a psychologist today.**

**Goals for treatment:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Is there any other information you think I should know?**