Registration Form

Intrigue Counseling / Abbee D. Smith, LCSW

227 Dixie Way N., Ste 210
South Bend, IN 46637

Phone: (574) 234-3515
Fax: (574) 234-3565

Date: _____ SS # _____-_____-_____

Name: _____ Date of Birth: _____
First Middle Initial Last

Email: _____

Address: _____ Phone # _____

_____ Cell # _____
City State Zip

Age:____ Sex: M / F Relationship Status: Single / Married / Separated / Divorced / Widowed / Significant Other

May we call you at home? Yes No May we leave messages at home? Yes No

Who referred you to this office, if anyone?_____ _____

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Employer: _____ Job Title: _____

Address: _____

May we contact you at work? Yes No Work Phone #: _____ - _____ - _____

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Spouse/
Sig. Other: _____ SS #: _____-_____-_____

Address: _____ Date of Birth: _____
(If Different)

Employer: _____ Job Title: _____

Work Phone: _____ - _____ - _____

Please list individuals who are important to, or who live with, you. (Children, parents, friends)

Name	Age	Relationship	Name	Age	Relationship

Someone (other than spouse) to contact in case of emergency:

_____ _____ _____
Name Relationship Phone #

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Present Situation (circle any that apply):

Nervousness	Depression	Fears	Motivation
Shyness	Interest in sex	Suicidal thoughts / Intent	Aggressiveness
Separation / Divorce	Homicidal thoughts / Intent	Finances	Sexual or physical abuse
Drug use	Alcohol use	Intimate relationships	Family relationships
Anger	Self-control	Unhappiness	Difficulty paying attention
Tension	Stress	Tiredness	Sleep problems
Legal matters	Headaches	Anxiousness	Urge to repeat actions
Too much energy	Panic attacks	Concentration	Mood swings
Loneliness	Feeling inferior	Isolation or withdrawal	Impulsivity
Education	Work or Career	Physical health problems	Troublesome thoughts
Temper	Nightmares	Marriage	Being a parent
Relationships w/ child(ren)	Eating problems	Stomach trouble	Bowel troubles

In your own words, please describe your present difficulties:

_____

_____

_____

Health Information:

Family Physician: _____ Last seen: _____

Date of last physical exam: _____

Are you on any medications? Yes No If yes, list the type of medication and reason for taking it.

_____ _____

_____ _____

_____ _____

Other significant health problems: _____

Psychotherapy is very personal and by ethical standards a confidential process. However, we often find it helpful to discuss treatment procedures with your personal physician especially when there are physical symptoms. Please sign your name below giving our professional staff permission to contact your personal physician regarding your care and any medications you may be taking.

Signature: _____ Date: _____

Have you had any previous therapy/counseling? Yes No If yes, please give Therapist/Doctor, Agency, and when.

_____

Psychiatric Hospitalization? Yes No If yes, when/where: _____

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Regarding Your Insurance:

If you would like us to file your insurance for you, it is necessary that you complete all of the following information. Please be sure to sign where indicated as this gives us permission to file for you and also to receive payment from your insurance company.

If you have any questions regarding the following, please ask the receptionist.

Policyholder's Name: _____

Policyholder's Date of Birth: _____

Policyholder's Employer: _____

Client's Relationship to Policyholder: _____

Identification #: _____ Group #: _____

Name of Insurance Company: _____

Address of Insurance Company: _____

Phone # to verify coverage: _____

Phone # for mental health benefit pre-certification: _____

_____

Printed Name of Client

_____

Signature of Client or Parent/Legal Guardian date