virginia lindahl Ph.D.
Therapy and Psychological Testing

CLIENT REGISTRATION FORM - ADULT

Today's Date:	
Client Information	
First Name	Last Name
Date of Birth	
Home phone number	Cell phone number
Occupation	Highest level of education
Emergency contact name Phone number	Relationship to you Alternative phone number
Who referred you?	

Please list all immediate family members. Please include name, relationship to you, age, location, and any mental illness.

Name	Relationship	Age	Location	Mental Illness

Medical History
Are you currently taking medication? Yes No
If yes, please list current medication names, dosages, and reason for taking.
Please list any significant medical history, including chronic conditions, accident, major illnesses, surgeries, etc.).
Please list any psychiatric diagnoses you have received in the past, including who diagnosed you and when.

Please list any psychiatric treatment you have received in the past, including psychotherapy and hospitalizations. Include reasons, locations, and timeframe.
Please list previous medications, when taken, for how long, and in what combinations (including past trials of medications for attention, anxiety, depression, etc.)

Reasons for Seeking Treatment
Why are you seeking therapy now?
Describe your goals for therapy.
Is there any other information that you think would be helpful in working with you?