Beth H. Hall, Ph.D., P.A.

Licensed Psychologist

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Registration Information

Name_____ Today's date_____

Date of birth_____

Age_____Gender_____

Height_____Weight_____

Address_____Apartment_____

City_____State_____Zip_____

Home Phone_____Cell_____

Work Phone_____Email_____

Marital Status:

_____Single_____Married_____Divorced_____Separated_____Widowed

Highest educational level reached _____

Employer_____ Hours worked per week_____

Primary Care Provider_____

Who referred you to our Practice?_____

Reason that you are currently seeking help?_____

_____

_____

_____

Have you Been in Therapy Before?_____yes_____no

Name of Therapist	When Started	When Stopped
_____	_____	_____
_____	_____	_____

Have you been hospitalized for Psychological Problems?_____yes_____no

Name of Hospital	When?	How Long?
_____	_____	_____
_____	_____	_____

Emergency Contact:

Name_____Relationship_____Number_____

Symptoms:

Anxiety
Impulsiveness
Poor Concentration
Mood Swings
Panic Attacks
Identity Issues
History of Physical Abuse
Sleep Disturbance
Appetite Disturbance
Isolation
Sexual Problems
Suicidal Thoughts
History of Self-mutilation
Phobias
Family/Relationship Issues
Impaired Memory
Paranoid Ideation
Depression
Low Self-esteem
Behavior Problems
Irritability
Excessive Worry
Health Concerns
Past Suicide Attempts
Self-Destructive Behavior
Substance Abuse
Death of Friend or Family Member
Financial Problems
Sexual Orientation Concerns
History of Sexual Abuse
Decreased Motivation
Feelings of Hopelessness
Racing Thoughts
Anger Issues Legal
Intrusive Thoughts

Past medical history_____

_____

_____

Past surgical history_____

_____

_____

Known allergies_____

Are you taking any medications?_____yes_____no

Name of medication Dosage

_____ _____

_____ _____

_____ _____

_____ _____

Do you use recreational drugs? _____ yes _____no

Do you smoke tobacco? _____yes_____no

Do you drink alcohol? _____yes_____no

If so, how often? _____daily_____weekly_____socially

How much?_____

Do you consider this a problem?_____If yes, why?_____

Have you had any previous suicide attempts or gestures? _____yes_____no

If yes, please explain_____

Please note any stressful or traumatic events that may have had impact on you

_____

Do you engage in any healy stress management activities?

_____

Do you have a regular routine of exercise, hobbies or social activities?

_____

Children:

Name	Age	Currently living with you?	If not, where?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who Currently Lives in Your Household?

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Insurance Information:

Insurance Company _____ID# _____

Group# _____ Policy Holder's Name _____

Relationship to Patient _____

Policy Holder DOB _____ Insurance Company Phone# _____

Signature _____ Date _____