Journey of Life Psychological, Inc.

REGISTRATION FORM

(Please Complete)

Today's date:	Primary Care Physician:

PATIENT INFORMATION

First name: Last Name:	☐ Mr. ☐ Mrs.	☐ Ms.	Marital status ☐ Single / ☐ Mar / ☐ Divorced ☐ Sep / ☐ Widowed

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Former name(s):	Date of Birth:	Age:	Sex: ☐ M ☐ F

REQUIRED FOR SERVICES ---------->	Social Security Number:	Mobile phone Number ( )

Home Address:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone Number: ( )	Preferred Method of Contact: ☐ Text ☐ Phone ☐ Email

Chose clinic because/Referred to clinic by (check all that apply):		☐ Insurance Plan	☐ Psychology Today.com

☐ Facebook	☐ Referral	☐ Close to home/work	☐ Google Search	☐ Insurance	☐ Yelp	☐ Other

INSURANCE INFORMATION

(ONLY COMPLETE IF APPLYING INSURANCE TO COVER THERAPIST FEE)

(Please provide your insurance card at your first appointment)

Patient's Name:	Date of birth:	Address (if different than above):	

Is this person a patient here?	☐ Yes	☐ No

Occupation:	Employer:	Employer address:	Employer Phone Number: ( )

Is this patient covered by insurance?	☐ Yes	☐ No

Please indicate primary insurance	☐ MHN	☐ Anthem Blue Cross	☐ Aetna	☐ Cigna	☐ Blue Shield of CA
	☐ Medi-Cal	☐ Medicare	☐ United	☐ Beacon	Other: _____

Patient's Member ID:	Patient's Group #:	

Subscriber's Name:	Subscriber's DOB:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	(please explain)

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Mobile phone Number: ( )	Home/Wk phone Number: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the therapist. I understand that I am financially responsible for any balance unpaid by me or my insurance company. I also authorize Journey of Life Counseling and Assessment Services or my insurance company to release any information required to process my claims.

E-Signature: Date: (format 01-01-01)

1. May we leave a message at the telephone numbers listed above? ☐ Yes ☐ No

   If no, how can we contact you?

2. Sexual Orientation(optional):

   ☐ Heterosexual
   ☐ Gay
   ☐ B-sexual
   ☐ Intersex
   ☐ Lesbian
   ☐ Questioning

3. Have you ever received inpatient services for the following:

   ☐ Mental Health Care Treatment ☐ Psychiatric Treatment (inpatient or medication)

4. Have you ever received outpatient services for the following:

   ☐ Mental Health Care Treatment ☐ Psychiatric Treatment (inpatient or medication)

5. Present state of health (check one)

   ☐ Excellent
   ☐ Good
   ☐ Fair
   ☐ Poor

6. Please list current medications you are taking:

7. Please list any significant medical history:

8. Please check any of the following you are currently experiencing:

☐ Academic Difficulties	☐ Emotional/Verbal Abuse	☐ Pregnancy and related concerns
☐ Alcohol/Drug Concerns	☐ Family Concerns	☐ Relationship Concerns
☐ Family Alcohol/Drug Concerns	☐ Finances	☐ Self-esteem/Confidence
☐ Anger/Irritability	☐ Friends	☐ Sexual Concerns
☐ Anxiety/Fear	☐ Gender Identity	☐ Sexual Abuse
☐ Assertiveness	☐ Grief/Loss	☐ Sexual Harassment
☐ Body Image	☐ Identity development	☐ Sexual Orientation
☐ Career Decisions	☐ Legal matters	☐ Sleep disturbance/Nightmares
☐ Concentration	☐ Loneliness	☐ Stress
☐ Cultural Concerns	☐ Making Decisions	☐ Suicidal Thoughts/Attempts
☐ Depression	☐ Parenting	☐ Unwanted Sexual Experience
☐ Disability Concerns	☐ Physical Abuse	☐ Other (Please specify)
☐ Eating/Appetite Concerns	☐ Physical Complaints	