REGISTRATION FORM

Psychological therapy

Consultant: Reena Sharma

CLIENT's Name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Email: _____ Gtalk/Skype ID: _____

Date of Birth: _____ Age: _____ SEX: M F Marital Status: _____

School & Grade or, if adult, Employer & Position: _____

IF CLIENT IS A MINOR:

Marital status of biological parents: ___Single ___Married ___Div/Sep ___Widow

If not married, status of custody: ___Joint ___Sole (Who: _____)

PARENTS DETAILS

MOTHER'S Name/Age: _____ Cell: _____

FATHER's Name/Age: _____ Cell: _____

Address (If different from patient): _____

Home Phone: _____ Office#: _____ Position: _____

Email: _____ Employer: _____

***If married,* SPOUSE**'s Name: _____ Primary Phone #: _____

Address (If different from patient): _____

Home Phone: _____ Work Phone: _____ Cell: _____

Employer: _____ Position: _____

FAMILY HISTORY :

NAME OF THE FAMILY MEMBERS (SIBLINGS)	RELATION	OCCUPATION/EDUCATIONAL QUALIFICATION	MARITAL STATUS

REASON FOR SEEKING PSYCHOLOGICAL THERAPY /CONSULTATION:

_____

_____

CLIENT'S MEDICAL HISTORY: _____

Last Physical Exam:_____ Height:_____ Weight:_____

Prescription medication being taken? _____

_____

Any surgery (when, cause, time): _____

PERSON RESPONSIBLE FOR PAYMENT: _____

Name (If not listed above): _____

City/State/Zip:_____

Home Phone:_____ Work Phone:_____ Cell:_____

PLEASE NOTE

- **YOU HAVE SIGNED UP FOR PREPAID SESSIONS**
- **FAILURE TO CANCEL AN APPOINTMENT WITHIN 24 HOURS OF THE SCHEDULED TIME WILL RESULT IN A FULL CHARGE TO ACCOUNT**
- **SESSIONS NEED TO BE RENEWED WHEN THE CLIENT HAS LAST SESSION LEFT IN THE BALANCE OF PREPAIS SESSIONS**
- **EACH SESSION WILL LAST 45 MINS - 1 HOUR ONLY AND ANY EXTENSIONS WILL LEAD TO EXTRA CHARGES, BASIS THE AVAILABILITY OF THE THERAPIST.**
- **PAYMENT NEEDS TO BE TRANSFERRED TO THE SAID ACCOUNT. WE WILL GLADLY FURNISH YOU WITH A RECEIPT.**
- **I HAVE READ AND AGREE WITH THE ABOVE STATED TERMS.**

INFORMED CONSENT

I hereby, give my consent to record my personal information, which is important for the psychological assessments (if req), plan intervention, and in order to undergo psychological therapy sessions. I understand that this information would be kept confidential and secured.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY Date

_____

Please print name