Whitten Psychological Service, PLLC
1028 Main Street, Shelbyville, KY 40065
Phone: (502)647-2477 Fax: (502) 371-0890

Adult Registration Information

Today's Date_____ Sex: Male Female

Client's Last Name First Name Middle Initial

_____

Social Security # Birthday Age

_____

Street Address City State Zip Code

_____

Home Phone Cell Phone Email Address

_____

Employer Work Phone Occupation

_____

Name of Primary Care Doctor Phone Number Fax Number

_____

Primary Care Doctors Address City State Zip Code

_____

Marital Status: Single Married Separated Divorced Widowed

What Brings You in:

Below are problems that some people face. Please circle those that pertain to you:

Change in appetite/weight	Feelings easily frustrated	Feeling isolated or withdrawn
Nightmares	Physical/Sexual Abuse	Obsessions
Suicidal Thoughts	Cutting/Burning Self	Mood Swings
Excessive Worrying	Drug/Alcohol Use	Impulse
Nervousness	Work Trouble	Parenting Struggles
Panic Attacks	Relationship Trouble	Hallucinations
Shyness	Trauma	Physical Health Problems
Stress	Eating Problems	Anger/Irritability
Depression	Sleep Problems	Hyperactivity
Concentration	Fears	Less interested in activities/recreation
Motivation	Finances	

Medical History

Describe any medical problems (please focus on medical problems that are interfering with your ability to work):

_____

_____

_____

How would you rate your overall health? 1 2 3 4 5

Poor Neutral Excellent

Please list any medications you are currently taking:

_____

_____

_____

Describe any head injuries (example: motor vehicle accidents, sports injuries, hit in the head, falling down.) Did you experience loss of consciousness? If so, for how long?

_____

_____

_____

Have you been hospitalized or had surgery for any reason (if yes, please give details and dates.)

_____

_____

_____

Substance Use History

How frequently do you drink alcohol? _____How much do you drink? _____

Do you use other drugs besides alcohol? _____If yes, what drugs? _____

Do you smoke or use tobacco? _____How cigarettes/tobacco use per day? _____

Have you ever felt that you should cut down on your use of drugs/alcohol?

_____

Have you ever received treatment for alcohol or other drug use? (if yes, please describe treatment and state how long you were in treatment and if you completed.)

_____

_____

Education History

Highest grade completed_____ College Classes_____

If you did not graduate high school, please explain why:

_____

Please describe any problems you had in school (learning, behavioral, or other)

_____

_____

_____

Were you in special education classes? _____If so, what grades? _____

_____

Did you have friends in school? _____

What type of extracurricular activities were you involved in?

_____

_____

Behavioral Health History

Please describe any history of mental health problems such as depression or anxiety.

_____

_____

_____

Have you ever received counseling for psychological or mental health problems?

_____

If yes, did you see a counselor (other than a medical doctor) that helped you work on your mental health issues? _____ If yes, when was your first session?

_____

When was your last session? _____

Any history of physical abuse? _____ If yes, please give age at time of occurrence.

_____

Any history of sexual abuse? _____ If yes, please give age at time of occurrence.

_____

Any history of domestic violence, verbal abuse, emotional abuse, or other mistreatment?

_____

Was your childhood (circle one) Happy Chaotic Unhappy Normal Uneventful

Please describe any family history of mental illness (such as depression or anxiety) or substance abuse issues.

_____

_____

Employment History

Please list your last three places of employment, and the duration of employment. (Ex: Ford Motor Company, 1990-1999)

_____

_____

_____

Appointment Reminders

Our system sends appointment reminders, please choose **one** preferred method.

☐ Text Number: _____

☐ Voicemail Number: _____

☐ Email Email: _____

☐ No Reminders

Is it okay for our staff to leave a message on the number you have provided? Yes ☐ No ☐

EMERGENCY CONTACT INFORMATION

Emergency Contact Name_____

Phone #_____ Alternate Phone #_____

Relationship to Client_____

How did you find out about our practice?

_____

Insurance Information

In order for us to file bills with your insurance you must complete all of the following information. We will also need a copy of your insurance card(s).

_____	_____
Policyholder's Name	Policyholder's Date of Birth
_____	
Insurance Company	
_____	_____
Identification Number #	Group #
_____	_____
Policyholder's Employer	Client's Relationship to Policyholder

- I understand that certain information about me can be released to insurance companies in order to process claims.
- I understand that co-pays are due at the time of service.
- I am financially responsible for services rendered that are not covered by my insurance company.
- I authorize payment of medical benefits to the provider for mental health services delivered.
- **I understand that failure to give 24-hour notice may result in a cancellation fee of $50.00.**
- **Whitten Psychological Services reserves the right to discontinue services after 2 consecutive missed or rescheduled appointments.**
- I hereby give permission to Whitten Psychological Services to provide me with mental health services within the provider's license and training.

_____	_____
Patient/Client Signature	Date