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Dr. Joti Samra, R.Psych. | Clinical Psychologist

CLIENT REGISTRATION FORMS

(REVISED AUGUST 19, 2011)

IDENTIFYING INFORMATION:

File Number: ____________ **Referral Source:** ____________ **Date:** ____________

Name: ____________ **Sex: M F** **Date/Place of Birth:** ____________

Ethnicity: ____________

Home Address: ____________ ____________ **Home Number:** ____________ **Is it OK to contact you at home?** **Y N**

DEMOGRAPHIC INFORMATION:

Place of Employment: ____________ **Position:** ____________ **Length of time at position:** ____________

Work Address: ____________ **Work Number:** ____________ **Is it OK to contact you at work?** **Y N**

Emergency Contact Name: ____________ **Emergency Contact Number:** ____________ **Relationship to you:** ____________

FAMILY HISTORY:

Marital Status: ____________ **Name of Spouse/Partner:** ____________ **Contact number:** ____________

Do you have any children (biological children, step-children, adopted)? Y N

Child's Name:	Date of Birth:	Grade:	Residence:	Health problems?

MEDICAL, PSYCHOLOGICAL & PSYCHIATRIC HISTORY:

Family Physician:	Address/City:	Phone:

Date of last complete medical exam: ______________________

Please list all medications you are currently taking:

Name of Medication/Dosage:	Prescribed for:	Prescribing physician:

Please list any MEDICAL difficulties/illnesses you have had (including hospitalizations, surgeries, other treatment):

Problem:	Date(s):	Treatment:

Please list any PSYCHOLOGICAL/PSYCHIATRIC difficulties/illnesses you have had (including professionals seen and treatment):

Problem:	Date(s):	Treatment:

EDUCATIONAL & WORK HISTORY:

What is the highest level of education you have completed? ____________________

What were your marks in school?

Elementary school: _______

High school: ____________

Post-secondary: _________

Did you ever have any difficulties with school (e.g., learning to read or write; learning disabilities?). Please describe:

____

____

____

Did you ever fail any grades? **Y N** **Describe:**

____

____

Is there any other information that you feel would be important for Dr. Samra to know?

____

____

Client Signature: ____________________ **Date:** ____________________