

# Desired Outcomes

8050 Beckett Center Dr. 314

West Chester, OH 45069

Today's Date: \_\_\_\_\_

## CLIENT REGISTRATION FORM

<b>Responsible Party</b> _____		
FIRST	MIDDLE	LAST
ADDRESS _____		
NUMBER	STREET	CITY STATE ZIP
SS# _____	DATE OF BIRTH _____ / _____ / _____	Referred by _____
MO	DAY	YR
PHONE #: _____		
HOME	WORK	ext CELL / PAGER
EMAIL _____		
<b>EMPLOYER</b> _____	<input type="checkbox"/> <b>Employment Status</b>	<input type="checkbox"/> <b>Shift</b>
ADDRESS _____	<input type="checkbox"/> <b>Job Level</b>	
NUMBER STREET	1 - Full Time	1 - First
	2 - Part Time	2 - Second
	3 - Casual/Contract	3 - Third
	4 - On leave	4 - Rotating
	5 - Retired	5 - Office/Clerical
CITY STATE ZIP	6 - Unemployed	6 - Skilled Craft
Occupation _____	7 - Student	7 - Labor
	8 - Other (specify): _____	8 - Sales
		9 - N/A or Other: _____

### CLIENT (if different than Responsible Party) – Try to complete ALL information requested.

FIRST _____	MIDDLE _____	LAST _____	ADDRESS _____
			NUMBER STREET
SSN# _____			CITY STATE ZIP
DATE OF BIRTH _____ / _____ / _____			EMAIL _____
MO DAY YR			
PHONE#: H: _____	W: _____	ext _____	Cell: _____
Emergency Contact : _____			Phone: _____

**HEALTH PLAN** \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY STATE ZIP

PHONE \_\_\_\_\_

**PRIMARY CARE PHYSICIAN** \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY STATE ZIP

PHONE \_\_\_\_\_

GROUP # \_\_\_\_\_ ID# \_\_\_\_\_ May we contact your PCP?  YES  NO

<input type="checkbox"/> <b>Sex</b> 1 - Male 2 - Female	<input type="checkbox"/> <b>Marital Status</b> 1 - Never Married 2 - Married 3 - Remarried 4 - Co-Habiting 5 - Life Partner 6 - Separated 7 - Divorced, Single 8 - Widowed, Single 9 - Other: _____	<input type="checkbox"/> <b>Educational Level</b> 1 - Not a High School Graduate 2 - High School Graduate / GED 3 - Some College or Technical School 4 - Technical/Associate Degree 5 - College Degree 6 - Some Graduate courses 7 - Graduate Degree 8 - Post-graduate Degree 9 - Other: _____	<input type="checkbox"/> <b>Relationship to Responsible Party</b> 1 - Self 2 - Spouse / Life Partner 3 - Dependent 4 - Other: _____
---	--	---	---

# Desired Outcomes

8050 Beckett Center Dr. 314

West Chester, OH 45069

## Others Living in Household:

Name	Age	Relationship (to Client)	Name	Age	Relationship (to Client)
1. _____	____	_____	5. _____	____	_____
2. _____	____	_____	6. _____	____	_____
3. _____	____	_____	7. _____	____	_____
4. _____	____	_____	8. _____	____	_____

## Presenting Problem(s):

Describe the problem(s) that brought you here today.

## Symptoms (please mark all that apply):

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Feeling hopeless                             | <input type="checkbox"/> Extreme sadness                 | <input type="checkbox"/> Depression                 |
| <input type="checkbox"/> Feeling of extreme happiness                 | <input type="checkbox"/> Feeling stressed                | <input type="checkbox"/> Self-esteem problem        |
| <input type="checkbox"/> Lack of enjoyment of usual activities        | <input type="checkbox"/> Easily irritated                | <input type="checkbox"/> Excessive worry            |
| <input type="checkbox"/> Feeling keyed up / on edge                   | <input type="checkbox"/> Feeling guilty                  | <input type="checkbox"/> Feeling nervous or anxious |
| <input type="checkbox"/> Fear of situations where escape is difficult | <input type="checkbox"/> Feeling fearful                 | <input type="checkbox"/> Sudden feelings of panic   |
| <input type="checkbox"/> Not getting along with friends / family      | <input type="checkbox"/> Perfectionism                   | <input type="checkbox"/> Obsessions or compulsions  |
| <input type="checkbox"/> Change in sleeping habits                    | <input type="checkbox"/> Trouble performing your job     | <input type="checkbox"/> Self-starvation            |
| <input type="checkbox"/> Paranoid thoughts                            | <input type="checkbox"/> Procrastination                 | <input type="checkbox"/> Reckless behavior          |
| <input type="checkbox"/> Indecisiveness                               | <input type="checkbox"/> Mind going blank                | <input type="checkbox"/> Hearing voices             |
| <input type="checkbox"/> Increased use of alcohol / drugs             | <input type="checkbox"/> Avoiding things                 | <input type="checkbox"/> Crying spells              |
| <input type="checkbox"/> Thoughts about hurting yourself              | <input type="checkbox"/> Thoughts about killing yourself | <input type="checkbox"/> Suicide attempts           |
| <input type="checkbox"/> Thoughts about hurting others                | <input type="checkbox"/> Thoughts about killing others   | <input type="checkbox"/> Acting violently           |
| <input type="checkbox"/> Problems with anger                          | <input type="checkbox"/> Intrusive thoughts              | <input type="checkbox"/> Poor interpersonal skills  |
| <input type="checkbox"/> Physical complaints of pain                  | <input type="checkbox"/> Chest pain                      | <input type="checkbox"/> Chronic pain               |
| <input type="checkbox"/> Memory problems                              | <input type="checkbox"/> Trouble concentrating           | <input type="checkbox"/> Low energy                 |
| <input type="checkbox"/> Lack of energy                               | <input type="checkbox"/> Numbness                        | <input type="checkbox"/> Dry mouth                  |
| <input type="checkbox"/> Change in appetite                           | <input type="checkbox"/> Stomach or bowel problems       | <input type="checkbox"/> Change in eating habits    |
| <input type="checkbox"/> Weight changes                               | <input type="checkbox"/> Chronic weakness                | <input type="checkbox"/> Nerve problems             |
| <input type="checkbox"/> Exaggerated startle response                 | <input type="checkbox"/> Trembling / twitching           | <input type="checkbox"/> Muscle tension / aches     |
| <input type="checkbox"/> Shortness of breath                          | <input type="checkbox"/> Heart symptoms                  | <input type="checkbox"/> Hot flashes                |
| <input type="checkbox"/> Frequent urination                           | <input type="checkbox"/> Trouble swallowing              | <input type="checkbox"/> Dizziness                  |
| <input type="checkbox"/> Sweating / clammy hands                      | <input type="checkbox"/> Change in sexual function       | <input type="checkbox"/> Change in sexual interest  |
| <input type="checkbox"/> Gender issues                                |  |   |

## Goals for Therapy:

What are your goals for treatment?	How will you measure improvement?
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

# Desired Outcomes

8050 Beckett Center Dr. 314

West Chester, OH 45069

## MEDICAL INFORMATION

What **medical health problems** do you have? Please explain.

Do you have any **allergies** (e.g., prescription medicines, over-the-counter- medicines, other things)?  YES  NO  
If YES, what are you allergic to and what kind of reaction do you have? Please describe.

Have you seen a doctor in the past year?  YES  NO If YES, please complete the information below.

Name of Doctor	Phone	Diagnosis	Purpose of Visit	Outcome
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you taking any medications?  YES  NO If YES, please complete the information below.

Medication	Purpose	Dosage	Start Date	Prescribed by
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

## SUBSTANCE ABUSE HISTORY

Have you used tobacco in any form?  YES  NO  
If YES, please describe the history and current pattern of your tobacco use.

Have you used alcohol?  YES  NO  
If YES, please describe the history and current pattern of your alcohol use.

Have you used caffeine (any form, including cola drinks)?  YES  NO  
If YES, please describe the history and current pattern of your caffeine use.

Have you used illegal drugs of any kind?  YES  NO  
If YES, please describe the history and current pattern of your drug use, including which drugs.