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

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CLIENT REGISTRATION FORMS

(REVISED AUGUST 19, 2011)

IDENTIFYING INFORMATION:

File Number: _____

Referral Source: _____

Date: _____

Name: _____

Sex: M F

Ethnicity: _____

Date/Place of Birth: _____

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:** _____