

Fredric Provenzano, Ph.D., NCSP

Private Practice in Psychology

5506 33rd Ave. NE, suite D
Seattle, WA 98105

Fredric Provenzano, Ph.D., NCSP, Psychologist, WA lic. # PY00001022
Lauren Christophersen, Office Coordinator

Phone: 206/361-2343
Fax: 206/361-0353
www.drfredprovenzano.com

Adult Client Registration Form

Today's Date: _____

Referred by: _____

Name: _____ **DOB:** _____ **SSN:** _____

Mailing Address: _____ **City:** _____ **Zip:** _____

Billing Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Mobile/Message Phone:** _____

May we call you at home? Yes No Okay to leave message at home? Yes No

Ethnicity: _____

Occupation: _____ **Employer:** _____

Work Address: _____ **City:** _____ **Zip:** _____

Work Phone: _____ May we call you at work? Yes No Okay to leave message? Yes No

Circle Current Status: Single Married Separated Widowed Divorced

Spouse/Partner Name (if appropriate): _____

How long in Relationship? _____

Names & Ages of Children: _____

Emergency Information

Emergency Contact Name: _____ **Rel. to Client:** _____

Contact Home Phone: _____ **Contact Work Phone:** _____

Primary Care Physician: _____

Physician Phone: _____ **Fax:** _____

Physician Address: _____ **City:** _____ **Zip:** _____

Insurance & Health Care Information (Please submit your insurance card at first session so we can Xerox a copy)

Primary Insurance Company: _____ **Phone:** _____

Insured's Name: _____ **Insured's DOB:** _____

Relationship to Client: _____ **Insured's SSN:** _____

Group/Employer Name: _____ **ID #:** _____

Group #: _____ **Authorization/Claim # (if applicable):** _____

Secondary Insurance Co. Name: _____ **Phone:** _____

Insured's Name: _____ **Insured's DOB:** _____

Relationship to Client: _____ **Insured's SSN:** _____

Group/Employer Name: _____ **ID #:** _____

Group #: _____ **Authorization/Claim # (if applicable):** _____

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Lauren Christophersen, Office CoordinatorPhone: 206/361-2343
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www.drfredprovenzano.com**ADULT CLIENT HISTORY**

Name _____ Today's Date: _____

Birthdate _____ Current Age _____

Gender: Male Female Other (please indicate) _____

Occupation _____

Employer _____ Typical Work Hours _____

Ethnicity: _____ Primary Language: _____

Other languages you speak: _____

FAMILY**Marital Status (circle):** Married Domestic Partner Separated Divorced Widowed Never Married

Spouse/Partner Name _____ Age _____ Relationship Length _____

Spouse/Partner's Occupation _____ Employer _____

Were you married previously? _____ If yes, how many times: _____

Your Children Living with You: (Please indicate if adopted or step-children)

Name _____ Age _____ Gender _____

Student/Occupational Status _____ School/Employer _____

Name _____ Age _____ Gender _____

Student/Occupational Status _____ School/Employer _____

Name _____ Age _____ Gender _____

Student/Occupational Status _____ School/Employer _____

Your Children Living Separately from You: (Please indicate if adopted or step-children)

Name _____ Age _____ Gender _____

Student/Occupational Status _____ School/Employer _____

Name _____ Age _____ Gender _____

Student/Occupational Status _____ School/Employer _____

Name _____ Age _____ Gender _____

Student/Occupational Status _____ School/Employer _____

Others Residing in Home:

Name	Relationship to You	Age	Gender	Student/Occupational Status

Pets: Please list any pets living with you: _____
_____.

Family of Origin:

Parent 1: Name _____ Current age: _____ Where living _____

If deceased, age at death _____ Cause of death _____

Parent 2: Name _____ Current age: _____ Where living _____

If deceased, age at death _____ Cause of death _____

Siblings:

Name	Age	Gender	Student/Occupational Status	Location

EDUCATION

1. Highest level of formal education achieved _____

2. Schools Attended:

Name of High School: _____ Year Graduated _____

Name: _____ Degree _____ Year Awarded _____ Major _____

Name: _____ Degree _____ Year Awarded _____ Major _____

3. Did you receive any special educational/remedial services/accommodations in school? Please explain:

_____.

4. Other Training, Apprenticeships, etc.:

Where Attended: _____ Type of Training _____ Years Attended _____

Where Attended: _____ Type of Training _____ Years Attended _____

MEDICAL/DEVELOPMENTAL HISTORY

1. Name(s) of your Physicians:

Primary Care Physician _____ Location _____

Physician Name _____ Specialty _____ Location _____

Physician Name _____ Specialty _____ Location _____

2. Please list medications currently taken by client, including dosage:

Medication _____ Dosage _____ For What Condition _____

3. Please list any significant illnesses, injuries, or hospitalization/surgeries experienced by the client:

Illness/Injury Approximate Date Hospitalized? Enduring Effects

4. Do you now or have you ever experienced any of the following (describe condition & approximate dates):

- a. Sleep problems _____
- b. Eating problems _____
- c. Unusual weight gain/loss _____
- d. Vision/hearing problems _____
- e. Cardiac/Heart Problems _____
- f. Allergies/Asthma _____
- g. Convulsions or seizures _____
- h. Nervous tics _____
- i. Chronic stomachaches _____
- j. Chronic headaches _____
- k. Concussions _____
- l. Diabetes _____

5. How often do you:

Smoke cigarettes/cigars/pipe _____ Drink alcohol _____

Use recreational drugs (list types) _____

6. Please list any significant medical or psychological history in your parents or siblings:

7. Please list any other current medical or psychological issues in the immediate or extended family that are contributing significant stress to the client:

8. Please list your previous psychotherapy, counseling, or psychiatric treatment or psychological evaluations:

Name/Treatment Location Approximate Date

9. To your knowledge, was there anything unusual about your mother's pregnancy with you or your birth?

10. To your knowledge, circle the description of your accomplishment of these developmental milestones:

	<u>Normal</u>	<u>Early</u>	<u>Late</u>	<u>Significant Delay</u>	<u>Don't Know</u>
a. Beginning to walk:	_____	_____	_____	_____	_____
b. Beginning to talk:	_____	_____	_____	_____	_____
c. Speak in sentences:	_____	_____	_____	_____	_____
d. Bladder control:	_____	_____	_____	_____	_____
e. Bowel control:	_____	_____	_____	_____	_____
f. Ride a bike:	_____	_____	_____	_____	_____
g. Begin to read:	_____	_____	_____	_____	_____
h. Begin to write:	_____	_____	_____	_____	_____

OTHER SOCIAL BACKGROUND

1. How would you describe your friendships and social life?

- I'm a loner.
 I have one close friend.
 I have several close friends.
 I have one/several close friends and a wider group of casual friends.
 I don't have any close friends but have lots of casual friends and acquaintances.

2. Check all of the descriptions below that apply to you:

- I make friends easily.
 I have long-term friendships that I've maintained over many years.
 I have an active social life.
 I tend to socialize only with family members.
 I initiate social activities with others (friends, family) frequently.
 It's hard for me to make friends.
 I think of myself as a leader.
 I am more a follower than a leader.
 I'm not really a leader or a follower but more of an active contributor and supporter in my social realm.

3. Religious Affiliation _____

Church Participation (circle one): active causal occasional not attending

4. List any hobbies, sports, clubs/organizations, or other special interests: _____

5. Who do you consider to be your heroes, or people that serve as a role model for you? _____

What other information do you think that I should know to help me work with you?

What are the goals that you'd like us to address in our work together?

Signature of person completing this form

Date

Relationship of person completing for the client if not the client

Thank you for taking the time to complete this form. It will help in understanding and facilitating the changes that are the goal of these services.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by contract.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Client Signature (Parent/Guardian if Minor)

Date

Printed Name

Co-Signature (if required)

Date

Printed Name of Co-Signer

Original 4/14/03; Revised 8/18

Note: A complete text of this agreement is included in your packet. Please sign and date this copy for Dr. Provenzano's records. You do not need to sign the copy of the agreement in your packet.

Please complete other side >>>>

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Request for Confidential Handling of Health Information

A. I, _____, request that
(Print First & Last Name of patient/recipient or parent/guardian)

Fredric Provenzano, Ph.D. handles my confidential health information regarding me/my child in the following way:

All reasonable requests to receive communication of your health information by alternative means will be granted. Please describe the alternative means (e.g. US mail, telephone call, etc.) by which you prefer to receive your health information.

Note: E-mail communication is not provided by Dr. Provenzano.

Telephone (please indicate: home / work / cell)

Voicemail (please indicate: home / work / cell)

U.S. mail

Fax (If marked: should we call before faxing to insure confidentiality? _____)

Other (please describe): _____

B. All reasonable requests to receive communication of your health information to alternative locations will be granted. Please list an alternate address below *only if you want communications regarding your health care information sent to an address that is different from your residence.*

(Street Address)

(City)

(State)

(Zip Code)

(Signature)

(Date)