Jan L. Nix, Ph.D.
Licensed Clinical Psychologist License No. 0001046

ADULT & COUPLES REGISTRATION

TODAY'S DATE: _____

CLIENT'S NAME: _____ DATE OF BIRTH: _____
First M.I. Last

ADDRESS: _____ _____ _____ _____
Street City State Zip

EMPLOYER (or school if a student): _____ WORK PHONE: (_____)_____

SEX: Male / Female MARITAL STATUS: Single / Married / Domestic Partner HOME PHONE: (_____)_____

CELL PHONE: (_____)_____ E-mail Address: _____ Preferred Daytime Phone? Hm / Wk / Cell

PHYSICIAN: _____ EMERGENCY CONTACT : _____ Phone: (____)_____

REFERRED BY: _____ PREVIOUS COUNSELING WITH: _____

REGULAR MEDICATIONS: _____

ALLERGIES: _____

SIGNIFICANT HEALTH ISSUES: _____

SPOUSE/PARTNER: _____ DATE OF BIRTH: _____

Address (if different from above): _____

HOME PHONE: (_____)_____ CELL PHONE: (_____)_____ Preferred Daytime Phone?: Hm / Wk / Cell

EMPLOYER: _____ WORK PHONE: (_____) _____

PRIMARY INSURANCE CARRIER: _____ Policy #: _____Group Number #: _____

Policy Holder's Name: _____ Employer: _____

Policy Holder's Address: _____ Birthdate: _____ Phone: (___)_____

SECONDARY INSURANCE CARRIER: _____ Policy #: _____Grp Number #: _____

Policy Holder's Name: _____ Employer: _____

Policy Holder's Address: _____ Birthdate: _____ Phone: (___)_____

BILL ANY OUTSTANDING BALANCE TO: NAME: _____ Relationship to Client: _____

ADDRESS: _____ _____ _____ _____
Street City State Zip

(Please note that any outstanding balances will not be billed to a third party without his/her express written consent.)

FAMILY MEMBERS (please include parents & adult children):

Name	Relationship	Age	Living in Home?
> _____	>_____	>_____	Yes/No
>_____	>_____	>_____	Yes/No
> _____	>_____	>_____	Yes/No
> _____	>_____	>_____	Yes/No
> _____	>_____	>_____	Yes/No
> _____	>_____	>_____	Yes/No
> _____	>_____	>_____	Yes/No
> _____	>_____	>_____	Yes/No
> _____	>_____	>_____	Yes/No
> _____	>_____	>_____	Yes/No
> _____	>_____	>_____	Yes/No

FOR OFFICE USE ONLY: DSM CODE: _____ FEE SCHEDULE: _____