INTENTIONAL AGING
DR. CAROL STEPHENS PSYD., LP
drcarolsunvalley@gmail.com
612-251-7413

CLIENT REGISTRATION

Today's Date_____
Name _____ Date of Birth_____
Address _____
City_____State_____Zip_____
Phone # *Home* _____ *Cell* _____
Referral Source _____
Reason for Referral _____
_____
_____
_____
_____
Emergency Contact : *Name* _____*Phone #*_____
*Relationship to you*_____

Education: Highest grade/degree completed _____
_____
Occupation _____
Ethnic Identity _____ Religion/Spiritual Practice _____
Military_____
Current Relationship Status: *Single* *Partnered* *Married* *Separated* *Divorced* *Widowed*
Names/Ages of Partner/Children/Pets:
_____
_____
_____
_____
_____
Name of Power of Attorney, Idaho Paperwork has been officially witnessed and notarized Y N
_____

Medical and Mental Health Problems
_____
_____
_____
Medications, supplements, other current treatments _____
_____
_____
_____
_____

Alcohol use: type of beverage, frequency and amount_____

Other Chemical Use: frequency and amount _____

History of Drug or Alcohol Abuse and/or Treatment _____

History of Trauma or Abuse_____

Previous Therapy or Treatment_____

Reason for Seeking Therapy: Goals for Therapy _____

DR STEPHENS IS NOT A MEDICARE PROVIDER AND DOES NOT TAKE INSURANCE. WE ASK THAT YOU WILL PAY AT THE TIME OF SERVICES. IF PAYMENT IS DIFFICULT, WE HAVE ACCESS TO AVAILABLE FUNDS THROUGH THE SENIOR CONNECTION .

Email this to me or bring to first session - drcarolsunvalley@gmail.com

.ANY QUESTIONS OR OTHER CONCERNS?