Registration Form for Intermission Therapies, LTD.

Date:_____

Client full name: _____
Address: _____
City:_____ **State:**_____ **Zip:**_____
Home phone: _____ **Work phone:**_____
Cell phone: _____ **May we leave a message:** _____
Email:_____ **Can we send you info via email?** _____
Date of birth:_____ **Social Security#** _____
Sex: M__ F__ Single___ Married ___ Widowed ___ Other ___
Employed?_____ **By whom:** _____

Name of person responsible for account:_____
Relationship to client:_____
Address(if different than client's)_____
City:_____ **State:**_____ **Zip:**_____
Social Security# _____ **Date of birth of ins subscriber:**_____
Employer:_____
Will insurance be used?_____ **Insurance Co:**_____
Group ID:_____ **Policy number:**_____
Have you received preauthorization? _____
Do you have secondary coverage?_____
How were you referred to us? _____
May we thank them?_____
Check all areas that are a concern:

___Aggression, violence	___Fatigue,tiredness	___Self-esteem issues
___Alcohol use	___Fears,phobias	___Self- neglect
___Anger, arguing, irritability	___Financial problems	___Sexual issues
___Anxiety, nervousness	___Friendships	___Suicidal thoughts
___Career concerns	___Gambling	___Temper problems
___Childhood issues	___Grieving,mourning	___Mood swings
___Codependence/Dependence	___Guilt	___Nervousness, tension
___Confusion	___Headaches	___Obsessions, compulsions
___Compulsions	___Work problems	___Panic or anxiety attacks
___Custody of children	___Health, illness,physical problems	___Perfectionism
___Decision making	___Inferiority feelings	___Pessimism
___Delusions	___Interpersonal conflicts	___Procrastination, laziness
___Depression	___Impulsive, loss of control	___ School/Work problems
___Divorce,Separation	___Irresponsibility	___Self-centeredness
___Drug Use	___Judgement problems, risk taking	___Shyness, oversensitive
___Eating problems	___Loneliness	___Sleep problems
___Emptiness	___Marital Problems	___Suspiciousness
___Failure	___PMS, menopause	___Withdrawal, isolation

Other: _____

Signature of client: _____

If patient is a minor, I consent for my minor child to be treated at Intermission Therapies, Ltd.
Signature of parent: _____