Jeffry Stine, Psy.D
Licensed Clinical Psychologist
4044 N. Lincoln Ave, Suite 461
Chicago, IL 60618

Registration Form

Client Information (Who is receiving services):

Client's Name: ______________________________ Date: _____________

SS#: ______-____-______ Date of Birth: ____________Age: ___________

Address:____

City:__________________State:_________________Zip Code:____________________

Gender:_______________ Ethnic/Racial Identity:________________________________

Occupation:__________________________Relationship Status:______________________

Primary Responsible Party (Person responsible for any charges or fees not covered by insurance):

Responsible Party: ___________________________ Relationship to Client: ___________

Responsible Party SS#: ______-____-______ Responsible Party Date of Birth: ________

Address (If different from above):____

City:__________________State:_________________Zip Code:____________________

Responsible Party Employer: __________________Occupation:____________________

Contact information to schedule appointments:

- ☐ Home:_______________________________________Message OK? Yes No
- ☐ Cell:____Voicemail OK? Yes No
- ☐ Email address:________________________________Email OK? Yes No

Who may I contact in case of an emergency?

Name:_______________________________Phone:___________________________

Relationship to you:___________________

Referral Source (Person or agency who recommended Dr. Stine to you)

Referred By: _______________________________________

☐ Insurance Company ☐ Web Search ☐ Psychology Today ☐ Other:________________

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Clinical Information:

Primary Care Physician: ________________________Phone:____________________________

Psychiatrist:__________________________________Phone:____________________________

Current Medical Conditions:____

Last medical physical:________/____________/___________

Please List Current Medications (both prescribed and over the counter):

Medication Name	Dose

Please describe your reasons for seeking therapy/assessment services:

What goals do you have for therapy/assessment? Please be specific.

Have there been any significant stressors, losses, or changes to you or your family within the last 6 months? If Yes, please describe:

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Have you received mental health services in the past? ☐ Yes ☐ No

Name:_______________________________Est Year:__________________________

Name:_______________________________Est Year:__________________________

*Have you attempted suicide or intentionally harmed yourself? ☐ Yes ☐ No

*Do you own or have access to firearms? ☐ Yes ☐ No

*Have you ever been hospitalized psychiatrically? ☐ Yes ☐ No

If Yes, for what reason:____

***Family History:** Please use the suggested abbreviation to mark if you or a relative has been diagnosed (X) or likely (L) has any of these health conditions:

	Self	Father	Mother	Sibling	Children	Maternal Grandparent	Paternal Grandparent
ADHD							
Learning Disability							
Autism							
Bipolar Disorder							
Panic Attacks							
Depression							
OCD							
Anxiety							
Drug Addiction							
Alcoholism							
Schizophrenia							
Thyroid Issue							
Sleep Disorder							
Heart Condition							
Suicide							
Other:							
Other:							

*This information is solely used to assist in understanding treatment concerns.