Jasmine Adams, LCSW (She/her)

3711 Long Beach Blvd. Suite 5039

Long Beach, CA 90807

Licensed Clinical Social Worker, LCSW#26038

PATIENT REGISTRATION

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_

Preferred Pronouns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, CA Zip:\_\_\_\_\_\_\_\_\_\_\_

Educational Level:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F \_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_ Message OK? ❑ Yes ❑ No Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: (\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_ Message OK? ❑ Yes ❑ No Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Phone: (\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_ Message OK? ❑ Yes ❑ No E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Home Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact Work Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom were you referred by/ how did you hear about my services?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consent to an appointment reminder service? Please circle: YES NO

Billing Information

Name: Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_

Address: City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, CA Zip:\_\_\_\_\_\_\_\_\_\_\_

SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DL#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F Relationship to Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Language spoken at home: ❑ English ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Please provide a copy of insurance card

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONFIDENTIAL HISTORY

Partner/ Marital Status: (Check all that apply.) Years Married:

❑ Married ❑ Living Together ❑ Never Married ❑ Divorced ❑ Separated ❑ Remarried

Partner’s Name *(If Applicable*): Highest Level of Education:

Occupation: Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:

If not married, are you currently in a romantic relationship? If yes, for how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 1 to 10 (10 being excellent, 1 being very poor), how would you rate your current romantic relationship?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children: (Please list deceased and/or living)

Name: Sex: ❑ M ❑ F Age:

Name: Sex: ❑ M ❑ F Age:

Name: Sex: ❑ M ❑ F Age:

Name: Sex: ❑ M ❑ F Age:

With whom were you raised? (Check all that apply.)

❑ Biological Parents ❑ Parents and Step Parent ❑ Foster Parents ❑ Single Parent ❑ Adoptive Parents

❑ Relatives ❑ Institution ❑ Legal Guardian ❑ Other:

Medical Conditions or Health Issues:

Current Physician: Phone #: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date and Reason of your last visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last physical?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: For What Condition:

Medication: For What Condition:

Please describe other serious illnesses or injuries:

How would you rate your current physical health on a scale of 1 to 10? (10 being excellent, 1 being very poor):\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate your current sleeping habits on a scale of 1 to 10? Please list any specific sleep problems you are currently experiencing:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any difficulties you experience with your appetite or eating patterns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a family history of treatment for psychological/psychiatric conditions? ❑ Yes ❑ No

Comments:

Have you had previous counseling or psychotherapy? ❑ Yes ❑ No

With whom and when:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently experiencing any overwhelming sadness, grief or depression? If yes, for approximately how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever felt suicidal? ❑ Yes ❑No Do you feel this way now? ❑ Yes ❑ No Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently experiencing anxiety, panic attacks, or have any phobias? If yes, when did you begin experiencing this?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently experiencing any chronic pain? If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What significant life changes or stressful events have you experienced recently?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you involved in any legal proceedings? ❑ Yes ❑ No Comments:

Do you exercise? ❑ Yes ❑ No What type: Frequency:

Do you take sleeping pills? ❑ Yes ❑ No What type: Frequency:

Do you drink alcohol? ❑ Yes ❑ No What type: Frequency:

Do you use tobacco? ❑ Yes ❑ No What type: Frequency:

Do you use other drugs? ❑ Yes ❑ No What type: Frequency:

Additional Information:

If currently employed, what is your current employment situation?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you enjoy your work? Is there anything stressful about your current work?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you consider to be some of your strengths?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you consider to be some of your weaknesses?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your main concerns/reasons for seeking treatment?

***Please Check the items that cause you the most trouble in you life:***

Abuse \_\_\_\_\_\_

Addictions \_\_\_\_\_\_

Anger \_\_\_\_\_

Anxiety \_\_\_\_\_

Apathy \_\_\_\_\_

Carelessness \_\_\_\_\_

Doubts \_\_\_\_\_

Fear \_\_\_\_\_

Guilt \_\_\_\_

Headaches \_\_\_

Health \_\_\_\_\_

Impulsiveness \_\_\_\_

Inadequacy \_\_\_\_

Indecisive \_\_\_\_\_

Inferiority \_\_\_\_

Insecurity \_\_\_\_\_

Irresponsible \_\_\_\_\_

Loneliness \_\_\_\_

Lustful thoughts \_\_\_\_\_

Memory \_\_\_\_

Mood swings \_\_\_

Obsessive Thoughts \_\_\_\_

Panic \_\_\_

Poor concentration \_\_\_

Poor decisions \_\_\_\_

Rebellion \_\_\_\_

Rejection \_\_\_\_\_\_

Restlessness \_\_\_\_

Sadness \_\_\_\_\_

Sex \_\_\_\_

Spouse \_\_\_

Stress \_\_\_\_

Tardiness \_\_\_\_\_

Thought Process \_\_\_\_

Underachievement \_\_\_\_

Withdrawn \_\_\_\_

Worry \_\_\_\_\_

Please list all family members**, *including yourself***, aunts, uncles, brothers, sister, parents, grandparents and cousins who suffer from the following problems

Depression

Alcoholism

Drug Abuse

Addictions

Suicide Attempt/Completion

Suicidal Thoughts/Behavior

Psychiatric Hospitalization

Psychiatric Medications

Manic/Depression

Mood Swings

Schizophrenia

Thought Disorder

Developmental Delays

Seizures

Sleep Disturbance

Eating Problems

Coordination Problems

Hearing Problems

Head Injury

Speech Problems

Hypoglycemia

Anxiety

Unexplained Lapse in Time

Child Abuse

Incest

Grief Issues

Cancer or Other Health Issues

ADD or ADHD

Dyslexia

Processing Information Problems

Memory Problems

Reading Difficulties\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_