Floyd Covey, D.D.; Th. D.; Ph. D.; C. Carm. of C.T.P.; O.SS.T.
Bishop / Priest / Psychologist / Monk
Counseling from a Christian View
Soul Care and Wisdom Guidance

REGISTRATION FORM FOR ADULTS

PATIENT'S FULL NAME _____

AGE _____ **DATE OF BIRTH** _____ **MALE** _____ **FEMALE** _____

MARITAL STATUS: **MARRIED___SINGLE___DIVORCED___**

SEPARATED___WIDOWED___

STREET ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

HOME PHONE # _____ **WORK PHONE #** _____

CELL PHONE # _____ **BEST NUMBER TO REACH YOU** _____

EMAIL ADDRESS_____**@**_____

PLACE OF EMPLOYMENT _____

ADDRESS OF EMPLOYER _____

_____

OCCUPATION _____ **SS#** _____

FAMILY PHYSICIAN'S NAME _____

FAMILY PHYSICIAN'S PHONE / CITY _____

NAME OF PERSON OR AGENCY WHO REFERRED YOU TO US _____

_____

NAME OF RESPONSIBLE PARTY _____

RELATIONSHIP OF RESPONSIBLE PARTY TO PATIENT _____

ADDRESS OF RESPONSIBLE PARTY _____

HOME PHONE # _____**WORK PHONE #** _____

CELL PHONE # _____

RESPONSIBLE PARTY'S EMPLOYER _____

(rev. 2023)

PATIENT'S NAME _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY_____

POLICY NUMBER_____**GROUP #**_____

PHONE # OF INSURANCE COMPANY_____

ADDRESS OF INSURANCE COMPANY_____

_____

NAME OF INSURED_____

INSURED SS#_____ **INSURED BIRTHDATE**_____

RELATIONSHIP OF INSURED TO PATIENT_____

SECONDARY INSURANCE COMPANY_____

POLICY #_____**GROUP #**_____

PHONE # OF INSURANCE COMPANY _____

ADDRESS OF INSURANCE COMPANY_____

_____

NAME OF INSURED_____

INSURED SS#_____**INSURED BIRTHDATE**_____

RELATIONSHIP OF INSURED TO PATIENT_____

EMERGENCY NOTIFICATION

NAME OF CONTACT PERSON_____

ADDRESS OF CONTACT PERSON_____

_____

HOME PHONE #_____**WORK PHONE#**_____

CELL PHONE #_____

RELATIONSHIP OF CONTACT PERSON TO PATIENT_____

PATIENT'S NAME_____

MEDICAL INFORMATION

DO YOU HAVE ANY MEDICAL PROBLEMS? _____ IF YES, PLEASE EXPLAIN_____

_____

_____

DO YOU TAKE ANY MEDICATION_____ **IF YES, PLEASE LIST:**

NAME OF MEDICATION	DOSAGE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DO YOU SMOKE? _____YES _____NO

If yes, how much? _____ How long? _____

Do you use alcohol or other drugs? _____YES _____NO

If yes, what do you use? _____

How frequently? _____

How much? _____

Do you have a history of previous mental health services? _____Yes_____No

If yes, please list below:

Type of Service	Dates	Provider
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ARE YOU INVOLVED IN ANY SORT OF LITIGATION? _____YES _____NO

If yes, please explain: _____

_____

PATIENT'S NAME _____

RELIGIOUS AFFILIATION_____

* * * * * * *

PLEASE LIST YOUR LEISURE INTERESTS_____

_____

_____

* * * * * * *

WHAT DO YOU CONSIDER YOUR STRENGTHS? _____

_____

_____

_____

* * * * * * *

BRIEFLY DESCRIBE THE PROBLEM(S) OR ISSUES WHICH BROUGHT YOU HERE

_____

_____

_____

_____

_____

_____

_____

* * * * * * *

BRIEFLY DESCRIBE YOUR GOALS FOR THERAPY_____

_____

_____

_____

_____

_____

PLEASE SHOW YOUR INSURANCE CARD TO THE RECEPTIONIST SO THAT WE CAN MAKE A COPY OF THE CARD.