Joseph M. Springer, Ph.D., LLC

Registration and Background Form

In order to save time, please print this and fill it out before you come to your first appointment

Name: _____

Address: _____

Phone: _____ (preferred) _____(alternate)

Do I have your permission to speak to anyone other than you at the above phone numbers regarding such things as appointments, etc? _____ Yes _____ No
Note: Checking "Yes" above does **not** constitute a release to discuss confidential information.
If you checked "Yes" please indicated the individual or individuals with whom I am authorized to speak:
_____

Were you referred by another professional? _____ Yes _____ No

If, "Yes", by whom? _____

If you were not referred, how did you find out about my services?

_____

Have you checked with your insurance company regarding your coverage?
_____ Yes _____ No
If "No" I strongly advise you to check regarding your coverage ASAP. I do not process insurance or accept assignment except for Medicare and a few select contracts. Other than those previous exceptions, payment is expected at the time of service. I will give you a form that includes all of the information that your insurance company requires for reimbursement, which you can then submit to your health carrier to be directly reimbursed by them. Please be aware that this does **not** guarantee that my services are covered, as insurance plans differ, even within the same insurance company.

What is the reason for which you are seeking treatment? _____

_____

Have you been in treatment before for this, or other conditions? _____ Yes _____ No

If "Yes", please indicate the presenting problem(s), when and with whom you received treatment:

_____

_____

If you have been in treatment before, did you find it helpful? Why or why not?

_____

_____

Have you ever been psychiatrically hospitalized? _____ Yes _____ No

If "Yes", please indicate when and where: _____

_____

Please list your primary physician: _____

Please list any additional physicians or prescribers who you are seeing (including nurse practitioners):
_____

_____

Please list any medications and supplements that you are taking (including dose and prescriber):

_____

_____

Please list your consumption of any of the following:

Alcohol: _____ Yes _____ No Frequency _____

Street Drugs: _____ Yes _____ No Frequency _____

Caffeine : _____ Yes _____ No Frequency _____

Tobacco: _____ Yes _____ No Frequency _____

How far did you go in school? _____

Please list your present and previous jobs (include approximate dates of employment):

_____

_____

Have you ever been involved with the legal system (criminal or civil)? _____ Yes _____ No
If "Yes", please explain:

_____

Have you been in the military? _____ Yes _____ No

If "Yes" what is your discharge status? _____

Please list the people with whom you presently live and your relationship to them:

_____

_____

Please list any other significant people in your life and your relationship to them:

_____

_____

Please list the members of your family of origin (if you haven't already done so) and describe the quality of your relationships with them:

_____

_____

What is your religious/spiritual orientation and involvement (if any)? _____

_____

What organizations, hobbies or activities are you involved with? _____

_____

Please list any other information that you think would be important for me to know:

_____

_____