DSM-IV Diagnosis: _______
(*Please leave blank)*

NEW CLIENT REGISTRATION FORM

Erik R Jackson, Ph.D.
818 12th Avenue, Seattle, WA 98122

Date ____________________________________

Name ____

Age ____________Sex _________ Date of Birth ________________ SSN ___________________________

Address ____

City __________________________________ State ___________________Zip ____________________

e-mail (for scheduling purposes only, with your permission):____________________________________

Home Phone ________________________________at this # may I call you? Y / N Leave messages? Y / N

Cell Phone ________________________________at this # may I call you? Y / N Leave messages? Y / N

Work Phone ________________________________at this # may I call you? Y / N Leave messages? Y / N

Occupation ____

Employer ____

Work Address ____

City __________________________________State _____________Zip _____________

Who referred you to Dr. Jackson? ____

Billing, Insurance & Health Information:

Person Responsible for Bill _________________________________Relationship to You: ________________

Address ____

1. Insurance Policy Premera Regence Uniform Multiplan FirstChoice Aetna Other_______________

Name of Insured (subscriber) ____

SSN: ________________________________ Subscriber Date of Birth __________________________

Subscriber or ID# (include Alpha prefix) _________________________ Group # ______________________

Insurance Company Address ____

Insurance Company Phone _________________________________

Subscriber's Billing Address (if different from your own) ____

Subscriber's Phone (if different from your own) __________________________________

If this is a Managed Care Plan, did you obtain Pre-Authorization? ________

2. Secondary Insurance (if applicable) Premera Regence Uniform Multiplan FirstChoice Aetna Other______

Name of Insured (subscriber) ____

SSN: ________________________________ Subscriber Date of Birth __________________________

Subscriber or ID#__________________________________ Group # __________________________________

Insurance Company Address ____

Insurance Company Phone _________________________________

Subscriber's Billing Address (if different from your own) ____

Subscriber's Phone (if different from your own) __________________________________

If this is a Managed Care Plan, did you obtain Pre-Authorization? ________

Please take a few moments to answer some questions about your medical, emotional, and social history. If some of these questions may not apply to you, feel free to leave them blank. We will have an opportunity to discuss these in greater detail in our intake session(s).

Personal Information:

Please briefly describe your reason(s) for seeking psychotherapy at this time: ________________________

____

____

____

____

Describe any **previous psychotherapy/counseling and/or psychiatric hospitalizations or mental health-related Emergency Room visits**, including diagnoses, approximate dates, and treatment:

____

____

____

____

____

Relationship Status: Married Partnered Divorced Single Widowed Other:______________

If partnered, how long have you been in this relationship? ______________________________________

Spouse/Partner's Name ____

Who else lives in your household?

Name	Age	Relationship to you

Any children not living at home? ____

____

Your Educational Background: ____

____

Spiritual/Religious Activities (including meditation, religious services, retreats, yoga): _________________

____

Sexual Orientation:

Heterosexual _____ Bisexual _____ Gay/Lesbian _____ Other _____ Uncertain _____

Have you ever been abused?

Physically Yes _____ No _____ Uncertain _____

Emotionally Yes _____ No _____ Uncertain _____

Sexually Yes _____ No _____ Uncertain _____

Medical Information:

Name of Physician ____Dr.'s Phone________________________________

Current medical conditions:

(1) ____ (3) ____

(2) ____ (4) ____

Current medications (please also make note of supplements used for mental health purposes):

(1) ____ (3) ____

(2) ____ (4) ____

(5) ____ (6) ____

Any significant **past** medical history and treatments? ____

____

____

Describe your **current** use of (frequency and amount):

Recreational drugs ____

____

____

Alcohol ____

Tobacco ____

Caffeine ____

Have you ever had problems abusing substances (or have others expressed this concern)? Please describe:

____

____

Have you ever participated in treatment for substance abuse? Please describe:

____

____

____

Emergency Contact:

By providing the below information, I am allowing Dr. Erik Jackson or his staff to contact this person should there be an emergent reason to do so. No one will contact this person unless there is an emergency:

Name ____

Relationship to You ____

Address ____

City ______________________________________State __________ Zip ________________________

Home Phone _______________________Work Phone __________________Cell ________________

Thank you!