Reina Remy, LCSW (She/her)
(License #LCS23158)
8765 Aero Drive, Suite #311
San Diego, CA 92123
Phone: (619) 384-1598
Fax: (858) 225-5902

Client Registration Form

Please complete this form as fully as possible. *This information is **confidential*** and for our use only and will ***not*** be released to any person or group without your written consent. *Please print clearly.*

Client Information

Client's Assigned Name/Used by Insurance | *Chosen Name* | *Date of Birth* | *Age*

Preferred pronouns | *Identified Gender* | *Assigned gender at birth/used by insurance*

Home Address: street, Apt.# | *City, Zip Code*

Client's Phone # | *If under 18yrs, name of Guardian(s)* | *Guardian(s) Cellular Phone #*

Name of Emergency Contact | *Telephone #* | *Relationship*

Name of Referring Person

Briefly describe the concern or situation that brought you in today: _____

Responsible Party Information

Name of Responsible Party | *Date of Birth* | *Social Security No.*

Address: street, Apt.#, city, state, zip | *Phone #*

Primary Insurance Name | *Policy/Identification #* | *Group #*

Secondary Insurance Name (if applicable) | *Policy/Identification #* | *Group #*

Payment Authorization

I understand that it is my responsibility to pay for the fee established for professional services rendered to the above client. I hereby authorize payment of benefits directly to Reina Remy, LCSW.

Today's Date | *Signature of Responsible Party*

Family Information

Number of people in the client's current household: _____ Marital Status of Client: Single Married Committed Divorced Separated Widowed

Languages spoken if other than English: _____ Religious preference (Optional): _____

Please list client's immediate family including adult children and those not living with the client.

Name	Identified Gender	Birth Date	Relationships	Home

Educational/ Occupational Information

Is the client currently a student? ____ YES ____ NO Name of last school attended: _____

Highest grade completed: _____ Highest degree and major: _____

Does the client have any learning difficulties? ____ YES ____ NO
If yes, please briefly describe:

_____

Is the client currently: ____ Employed ____ Unemployed ____ Retired ____ Other (please specify): _____

Occupation: _____

Health Information

_____ _____

Name of client's primary care physician *Physician's telephone number*

Is the client currently under at doctor's care? ____ YES ____ NO If yes, for what reason?

_____

_____

List current medications client is taking:

Medication	Dosage	Prescribed by

Has the client received past counseling or psychotherapy? ____ YES ____ NO If yes, whom did the client see?

Whom did the client see?	Dates	For what reason?

Has the client received other health care services? ____ YES ____ NO If yes, whom did the client see?

Whom did the client see?	Dates	For what reason?