Teresa B. Olson, Psy.D.
8354 Princeton Glendale Rd. Suite 118
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Clinical Psychologist
Certified Clinical Hypnotherapist
(513) 860-3156
Fax: (513) 860-3157

CLIENT REGISTRATION

NAME: _____ DOB: _____

MARITAL STATUS: S M D W

ADDRESS: _____ HOME PHONE: _____

CITY/STATE: _____ WORK PHONE: _____

ZIP CODE: _____ CELL PHONE: _____

SSN: _____ EMPLOYER: _____

EMERGENCY CONTACT NAME AND PHONE

_____

REFERRED BY: _____

Please provide a brief summary of reasons for which you are seeking services: _____

_____

Please check the areas or symptoms for which you are seeking treatment:

_____ Anxiety/OCD	_____ Hypnotherapy	_____ Stress Management
_____ Depression	_____ Grief/Loss	_____ Clutter/Hoarding Issues
_____ Eating Disorder	_____ Adjustment Issues	_____ Life transitions

_____ Other:_____

_____ I agree to pay $150 for the Initial Assessment

_____ I agree to pay $160 for each 60 minute psychotherapy session

_____ I agree to pay $120 for each 45 minute psychotherapy session

_____ I agree to pay $80 for each 30 minute psychotherapy session

If needed, understand that I may establish a payment plan to help me meet my financial responsibility.

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR COMPLETE PAYMENT OF SERVICES RENDERED AND I ACCEPT THAT RESPONSIBILITY.

SIGNATURE: _____ DATE: _____

(over)

Please list ALL medications that you are currently taking: _____

_____

Please identify any allergies you may have: _____

_____

If you are currently under a physician's care, please indicate the name and phone number and the medical problem for which you are being treated: _____

_____

Please note any relevant medical history: _____

_____

_____

_____

Please indicate any previous experiences in therapy/counseling; include name, phone number, address of treating professional, dates, and length of treatment: _____

_____

_____

_____

_____

_____

Please indicate any previous hospitalizations (medical or psychiatric) including hospital name, dates, and reasons: _____

_____

_____

_____

Please note relevant family medical/psychiatric history; including relationship of family member and specific illness: _____

_____

_____

_____

_____

Please identify any substances (alcohol/drugs) you are currently using or have used in the past:

_____

_____

_____

_____

All information contained in this Client Registration form is the property of Teresa B. Olson, Psy.D. This information is confidential and will not be shared with anyone unless authorized by you in writing.