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REGISTRATION FORM

Name: _____ Referred by: _____

Age: _____ DOB (m/d/y): _____ Today's Date: (m/d/y) _____

Address: _____ City: _____ Postal Code: _____

Email: _____ May we send you email news bulletins? Yes No

Phone Number(s):

daytime _____

night time _____

May we call you there?

Yes No

Yes No

May we leave messages there?

Yes No

Yes No

If NO, please indicate the best way to reach you: _____

Person to notify in case of emergency: _____

Best way to reach this person: _____

1. Why are you seeking help at this time?

2. Who else have you seen for this or similar reasons? When and for how long?

3. Who are the people you live with and how are you related?

. . . continued reverse

4. Are you currently employed? Yes No Occupation: _____
5. What jobs have you done most recently? _____

6. What is the highest level of school you have completed? _____
7. Name, address and telephone number of your family physician: _____

5. When was your last physical checkup? _____ What were the results? _____

8. What medications are you taking at present and for what purpose?

Medication	Purpose
_____	_____
_____	_____
_____	_____

7. List all of the serious injuries, illnesses or operations in your lifetime.

8. Have you ever had a loss of consciousness? _____ If so what happened? _____

9. What problems or changes in hearing or seeing have you had? _____

10. What is your current mood? _____

11. What is your usual mood, if different from above? _____

12. What sleep difficulties have you had in the last month? _____

13. What problems have you experienced with your energy level (either too much or too little) in the last month? _____

14. How has your appetite for food been recently? _____

15. What changes in body weight have you had in the last 6 months? _____

16. What difficulties have you had recently in thinking (e.g. with your memory, concentration or speech)? _____

17. What role does spirituality play in your life? _____

18. What do you like to do for fun? _____