Chestnut Hill College
Psychological Services Clinic
Client Registration Form

Name of Client: _____ Date: _____ *Client ID#*_____
(Last) (First) (Initial)

Parent/Guardians (if applicable)_____

Address _____
(P.O. Box or Street) (City) (State) (Zip)

Telephone: _____/_____ Date of Birth: ____/____/_____ Age: _____
(Home) (work)

Phone(s): _____ email address: _____

OK to leave message on phone: ___ Yes ___No

Sex:
☐ Male ☐ Female ☐ Transgender

Relationship Status (if adult):
☐ Single ☐ Married ☐ Partnered

Years of Education

Military Status
_____ years ☐ Active ☐ Retired

SS# Last 4 Digits

Employer:_____

School and Grade:_____

Please check <u>all</u> that apply:
☐ African American ☐ Arab/Middle Eastern ☐ Asian/Pacific Islander ☐ European American
☐ Latino(a) ☐ Native American/Eskimo ☐ Other _____

Members of primary client's family (and others in your home):

Name	Sex, Age, and D.O.B.	Relationship to Primary Client

It is the PSC's policy to contact your emergency contact(s), the police, or both in the event of a medical of psychiatric emergency. Please sign assent to this:_____

Person to contact in case of emergency: _____ Telephone: _____
Name of nearest relative not living with you: _____ Telephone: _____

CLIENT'S SIGNATURE: I understand it is my responsibility for total payment of the bill for services provided, and that the Psychological Services Clinic does not bill insurance companies.

Name: _____ Date: _____
Client or Authorized Person's Signature