Dr. Kimberly Rubin Ph.D.
Licensed Psychologist

CLIENT REGISTRATION

Client's Name:_____ Date of Birth:_____

Client's Age:_____ Social Security:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ ☐ Yes, it is ok to leave message

Work Phone:_____ ☐ Yes, it is ok to leave message

Cell Phone:_____ ☐ Yes, it is ok to leave message

Email:_____ ☐ Yes, it is ok to use email to correspond

Insurance Co.:_____ Insurance ID#:_____

Emergency Contact:_____ Emergency Contact Phone:_____

Physician:_____ Phone:_____ Date of Last Appt._____

Psychiatrist:_____ Phone:_____ Date of Last Appt._____

How can I help you?:

Symptoms:

☐ Depression Mood ☐ Decreased Libido ☐ Sadness ☐ Low Self-Esteem

☐ Irritable Mood ☐ Psychomotor Agitation ☐ Decrease Interest or Pleasure

☐ Decrease Concentration ☐ Excessive Guilt ☐ Indecisiveness ☐ Recurrent Thoughts of Death

☐ Weight Gain ☐ Feeling Hopeless ☐ Decreased Energy or Fatigue

☐ Weight Loss From Not Dieting ☐ Feeling Worthless ☐ Increased Sleep

☐ Decreased Sleep ☐ Periods of High Energy ☐ Impulsive Behavior

☐ Increased Appetite ☐ Tearfulness ☐ Other_____

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Date of First Symptoms:_____ Previous Therapy?_____

Current Medications:_____

_____

_____

How did you hear about Dr. Rubin?:

☐ Insurance Referral ☐ Internet Search ☐ Website ☐ Referred by:_____

☐Other:_____

May we contact them to say thank you?:_____

If client is a minor, please complete the information below for all parents or guardians,

Parent/Guardian #1

Client's Name:_____ Date of Birth:_____

Client's Age:_____Social Security#:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____ ☐ Yes, it is ok to leave message

Work Phone:_____ ☐ Yes, it is ok to leave message

Cell Phone:_____ ☐ Yes, it is ok to leave message

Email:_____ ☐ Yes, it is ok to use email to correspond

Insurance Co.:_____ Insurance ID#:_____

Type of Insurance Policy.:_____ How much time does client live at this address:_____

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Parent/Guardian #2

Client's Name:_____ Date of Birth:_____

Client's Age:_____ Social Security:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ ☐ Yes, it is ok to leave message

Work Phone:_____ ☐ Yes, it is ok to leave message

Cell Phone:_____ ☐ Yes, it is ok to leave message

Email:_____ ☐ Yes, it is ok to use email to correspond

Insurance Co.:_____ Insurance ID#:_____

Type of Insurance Policy.:_____ How much time does client live at this address_____

I,_____ has been given a copy of Informed Consent for Psychotherapy. I have been given the opportunity to have any and all questions answered relevant to the proposed psychotherapy. I agree to enter into a courser of therapy with Dr. Kimberly Rubin Ph.D. of _____ at a rate of $_____per 50 minute sessions payable at the time of sessions.

Name of responsible party

Date

To be completed by therapist

Cancellation Policy:
I grant permission for case consult with other professionals as long as standard care is exercised to protect my privacy and confidentiality. I have been advised regarding the limits of above stated confidentiality and I agree that I will not authorize the execution of a subpoena for any purpose. I hereby authorize my therapist to resist subpoenas executed by any other person or persons in order to protect and insure my privacy and confidentiality. I have read and understand the information contained in the Client Information Sheet and initial registration package. I have been given the opportunity to have any and all question answered relevant to the proposed psychotherapy.

_____ Date:_____

Client / Parent / Guardian Signature

_____ Date:_____

Witness

199 North Main Street, Suite 105 ◆ Plymouth, Michigan 48170 ◆ 248-387-9495