

**Honora Hanley, Ph.D.**  
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**NEW PATIENT REGISTRATION**

This form requests information about you (or your child) which will help me design a treatment plan geared specifically to your needs. Please take a few moments to complete the form carefully. I appreciate your time and effort in completing this document. If you have any questions, please feel free to discuss them with me. Thank-you.

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_  Female  Male

City, State, Zip: \_\_\_\_\_ Occupation: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Home- OK to contact there? Y N      Work- OK to contact there? Y N

Emergency Contact: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Name      Relationship to patient      Phone Number

Relationship Status:  Single  Married/Partnership  Separated  Divorced  Widowed

Please list all persons living in your household, including their ages and relationship to you or your child:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary Care Physician: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

May I exchange information with your treating physician to coordinate your care?  Yes  No

By whom were you referred: \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

**SECONDARY INSURANCE INFORMATION**

Insured Name: \_\_\_\_\_

Insured Name: \_\_\_\_\_

Insured SSN: \_\_\_\_\_ DOB \_\_\_\_\_

Insured SSN: \_\_\_\_\_ DOB \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Payor/Health Plan: \_\_\_\_\_

Payor/Health Plan: \_\_\_\_\_

Patient's Relationship to the Insured:  
 Self       Spouse       Dependent

Patient's Relationship to the Insured  
 Self       Spouse       Dependent

Member/ID#: \_\_\_\_\_

Member/ID#: \_\_\_\_\_

Policy/Group: \_\_\_\_\_

Policy/Group: \_\_\_\_\_

Person Responsible for Bill:  Self

Other

**Honora M. Hanley, PhD----Child/Adolescent Supplemental Intake Form**

Child's Name: \_\_\_\_\_ Parent's Name: \_\_\_\_\_

**PROBLEMS: Please mark a C by the problems that are current, and a P by problems that occurred in the past.**

- School/Academic       Learning Disability       School/Behavioral       ADHD
- School Suspension       School Expulsion       Detention/Incarceration
- Peer Relationships       Temper/Anger       Social Withdrawal       Physical Aggressiveness
- Oppositionality/Defiance       Theft       Depression       Anxiety

Chronic Health Problems (specify): \_\_\_\_\_

Developmental Problems (Describe briefly): \_\_\_\_\_

Drug &/or alcohol use (Describe, including time of onset, types, and amount, if known): \_\_\_\_\_

Eating Disorder: (Describe briefly): \_\_\_\_\_

Sexual Issues (Describe briefly): \_\_\_\_\_

**EXTENUATING FAMILY FACTORS. Please check all that apply**

- Suspected child abuse/neglect
- Suspected child sexual abuse
- Parents' marital strife
- Either parent clinically depressed
- Either parent with pattern of criminal/antisocial involvement (briefly specify): \_\_\_\_\_

Either parent with alcohol abuse problem

Either parent with substance abuse problem

Either parent with other emotional/psychiatric problems (briefly specify): \_\_\_\_\_

Either parent with chronic health problem (briefly specify): \_\_\_\_\_

**OTHER LIFE EVENTS. Please check all that apply**

- Parents' separation/divorce       Either parent's remarriage/re-coupling
- Close friend or relative's death       Close relative or friend's death by suicide
- Immediate family member's inpatient treatment for psychiatric or drug/alcohol abuse problems.
- Change of school(s) in child's lifetime, since K (Please give number\_\_\_; most recent occurrence\_\_\_).
- Change of residences in child's lifetime between K and present (number\_\_\_; most recent\_\_\_\_\_).

**OTHER PROBLEMS AND RELEVANT BACKGROUND YOU WOULD LIKE ME TO KNOW.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_