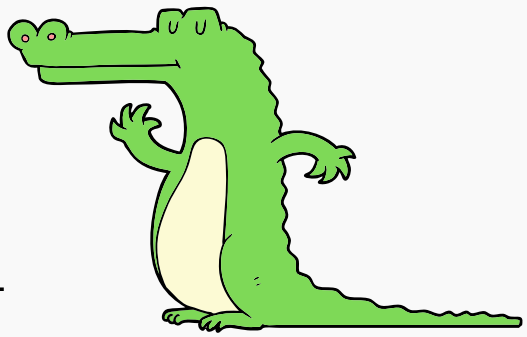
# The Integrative School Psychologist



## CLIENT REGISTRATION

Today's Date: ___/___/___ (Please Print)

| | | |
|---|---|---|
| Client Name-- Last | Client Name-- First Middle | |
| Address | City/State/Zip<br>/ / | |
| Date of Birth | TOB<br>___ : ___ am pm | Birth Place |
| Parent's Name & Phone<br>_____ (_____) _____<br>Email: _____ | | Are text messages okay to leave at your phone number? YES NO |
| Client School | Referred By | |
| Guidance Counselor's Name & Contact<br>_____ (_____) _____ | | |
| School Mental Health Clinician's Name & Contact<br>_____ (_____) _____ | | |
| Family Physician & Practice Name<br>_____<br>Contact Phone: (_____) _____<br>Any medical conditions you are being treated: __ Yes __ No<br>Please list condition & treatment type: _____<br>_____ | | I give consent to J.Celesta Training & Consulting to communicate with my child's care providers about my care (until further notice).<br>❑ Yes<br>❑ No<br>Initials _____ |
| Emergency Contact (Relationship to Client)<br>_____ | Emergency Contact Phone #<br>(_____) _____ | |

List three (3) goals you would like to accomplish with our services:

1. _____
2. _____
3. _____