GOLD PSYCHOLOGICAL SERVICES

Psychological, Forensic, Educational
and Therapeutic Services

701 E Brookside Lane
Hillsborough, NJ 08844

Phone: (973) 615-7759
Email: drgoldstein8@gmail.com

Web: www.goldpsychological.com

New Client Registration Form

Today's Date: ___________

Form filled out by: ____________________ Relationship to Client: __________________

IDENTIFYING INFORMATION

Client's Name: ___________________________ Gender:____________

Age: ________ Birthdate: ___ / ___ / ___

School Currently Attending: __________________________

Client's Address: ___________________________________

City: ___________________ State: ___________ Zip Code: ___________

Home Phone: _____________________ Cell Phone: _____________________

Self/Mother/Father (circle)

Email: __________________________________

Best way to reach you? (home, cell, email): ________________________

Can we contact you via text and/or email with appointment reminders? ☐ Yes ☐ No

Parent/Legal Guardian: ____

Relationship to Client: ___________________ Occupation: ____________________

Birthdate: ___ / ___ / ___ Highest Level of Education: _________

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Relationship to Client: ___________________ Occupation: ____________________

Birthdate: ___ / ___ / ___ Highest Level of Education: _________

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Client's Birth Parents (if not persons with legal custody)

Biological Father's Name: ____________________________ Birthdate: ___ / ___ / ___

Occupation: ______________________ Highest Level of Education: __________

Biological Mother's Name: ____________________________ Birthdate: ___ / ___ / ___

Occupation: ______________________ Highest Level of Education: __________

If the parents are divorced or separated: Date of separation/divorce: ________________________

Who has physical custody? _________________ Who has legal custody? _________________

Persons Currently Living In the Home with Client:

Name	Age	Sex	Relationship

Emergency Contact Information

Name: ____

Relationship to Client: ______________________________________

Home Phone: _______________ Cell: _________________ Work: ______________

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION?

Please Circle: Y N IF YES, WHOM? ______________________________________

Client's Primary Care Physician: __________________________________

Date last seen: _________________

Referred by: ______________________________________