**Dr. Gail Lisson, Psy.D.**
**CENTER FOR HEALTH SOLUTIONS, PLLC**
2500 Regency Parkway
Cary, NC 27518
Tel. (252) 206-6930
Fax. (919) 377-1420

## CLIENT REGISTRATION

CLIENT NAME:_____
ADDRESS_____
_____

TEL (HOME):_____
TEL (OFFICE):_____
TEL (CELL):_____

EMAIL:_____
DATE OF BIRTH:_____

GENDER: male female

EMERGENCY NAME(S) AND
NUMBERS:_____
_____

**PAYMENT POLICIES AND AUTHORIZATION:**

I authorize my provider and/or his agents to collect fees for services rendered to me and/or any other persons for whom I am responsible. I agree to pay in full at the time of service if Dr. Lisson is not a provider under my insurance plan. I acknowledge that my provider might not be a participating provider with my insurance carrier and that if he/she is not, then he/she will not submit insurance claims for me. If I choose to submit claims on my own behalf, reimbursements will be sent directly to me and not to my provider

**SIGNATURE:-**
**_____DATE_____**

*Cash and personal checks are welcomed. Clients are responsible for any returned check fees that are issued by provider's bank. Credit care payments can be made at www.gaillisson.com or processed within the office.*

**Providing the following information will assist me in your initial consultation:**

**Medical History**

Please list all your past and current medical diseases and conditions (including psychiatric or neurological conditions):

_____
_____
_____

Please list all your current medications, including over-the-counter medication and herbal supplements:

_____
_____

Please list all of your current physicians:

_____
_____

**Health Habits**

*Sleep:*
List your typical bed time:_____
List your typical wake time:_____
How long does it take for you to fall asleep?_____
How many times do you typically awaken in the middle of the night?_____

*Tobacco*
Do you currently use tobacco?_____
If yes, what type and how much per day_____

*Caffeine use*

| Type of caffeinated beverage | Amount | Time of Day |
|---|---|---|
| | | |
| | | |
| | | |

*Exercise*
What type of exercise do you do?
How often do you exercise each week

Substance Abuse History

| Drug type | Age started | Amount | Frequency | Route | Last use |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |