



The Nicholls Group  
9965 North 95<sup>th</sup> Street, Ste. 101  
Scottsdale, AZ 85258

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## **LEAP – Social Skills Group** **Registration Form**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Reason For Visit and Current Concerns: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please check one:

Married       Divorced       Separated       Widowed       Single

Who do you live with? \_\_\_\_\_

Are you currently employed?  Yes  No If yes, what is your occupation/position: \_\_\_\_\_

How many years of education do you have? \_\_\_\_\_

Highest degree obtained: \_\_\_\_\_

Do you currently have any medical conditions (chronic or acute)?  Yes  No

If yes, please describe: \_\_\_\_\_

Have you ever suffered an injury to your head?  Yes  No If yes, please explain: \_\_\_\_\_

What medications are you currently taking? \_\_\_\_\_

How much do you drink per day? \_\_\_\_\_ How much do you smoke per day? \_\_\_\_\_

Have you ever suffered an emotional or physical trauma?  Yes  No If yes, please explain: \_\_\_\_\_

Have there been any recent stressors in your life? (moving, a change in job, loss of a loved one, etc.)  Yes  No

If yes, please explain: \_\_\_\_\_

Have you been to a counselor, therapist, psychologist, or psychiatrist before?  Yes  No

If yes, please indicate when and the reason: \_\_\_\_\_

Have you ever been diagnosed as having a mental health disorder?  Yes  No

If yes, what was the diagnosis: \_\_\_\_\_

Have you ever tried to hurt yourself or attempted suicide?  Yes  No If yes, when? \_\_\_\_\_

Do you currently feel like you want to hurt yourself or attempt suicide? \_\_\_\_\_

How supportive are your friends/family?

Never       Seldom       Sometimes       Usually       Always

How often do you engage in social activities?

Never                       Seldom                       Sometimes                       Frequently

Please Check Yes or No:

Are you having any difficulty with sleep?    Yes    No

Have you had a recent loss or increase in your appetite?    Yes    No

Have you lost interest in activities?    Yes    No

Are you more irritable than usual?    Yes    No

Do you have a loss in energy or feel fatigued often?    Yes    No

Do you have problems concentrating?    Yes    No

Are you easily distracted?    Yes    No

Have there been any changes in your memory?    Yes    No

Do you worry often?    Yes    No

If yes, what types of things do you worry about? \_\_\_\_\_

Have you ever had a panic attack? \_\_\_\_\_

Return registration form and check made payable to:

**Sally J. Logerquist, Ph.D. Licensed Psychologist**

**P.O. Box 4673, Scottsdale, AZ 85261**