Saul and Saul, LLC
CONSULTING PSYCHOLOGISTS: TUCK T. SAUL, PhD & SUZANNE C. SAUL, PhD
CERTIFIED COACH: TUCK T. SAUL, PhD

REGISTRATION FORM (PLEASE PRINT)

Name:_____

Name I'd Like to Be Called:_____

Age:_____Date of Birth:_____SSN:_____

Street Address:_____

City:_____Zip:_____

Home Phone:_____Office Phone:_____

Cell Phone:_____

E-Mail Address:_____

Referred by:_____

Occupation:_____

Employer:_____

Highest Level of Education:_____

Marital Status:_____

Spouse/Significant Other's Name:_____

Age:_____Date of Birth:_____

Address (If Different from Above):_____

City:_____Zip:_____

Occupation:_____

Children (Names and Ages):_____

_____

355 E. Campus View Blvd., Suite 285 • Columbus, OH 43235
(614) 844-6886 • Fax: (614) 844-6866
www.saulandsaul.com

Personal Physician:_____ Phone:_____

Previous Psychologist(s) and/or Mental Health Provider(s) (Names & Dates Seen):_____

_____

_____

Any Current Medications:_____

_____

In Case of an Emergency, Name of Contact Person:_____

Phone:_____

Please explain your current concerns which you would like to address:_____

_____

_____

_____

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I REQUEST CONSULTATION AND TREATMENT BY THE PSYCHOLOGISTS AT SAUL AND SAUL, LLC. I HAVE REVIEWED AND UNDERSTAND THE STATEMENT OF OFFICE POLICIES FOR THESE SERVICES. I HAVE BEEN NOTIFIED ABOUT THE LIMITS OF CONFIDENTIALITY.

Print Name:_____ **Today's Date:**_____

Signature:_____