CLIENT REGISTRATION FORM

Date:_____

Please complete the following information about yourself. This information will be kept confidential. If you have any questions, please ask your therapist.

Client Name_____ Birth Date_____

Social Security Number_____ Gender M_____F_____

Phone Number(s) Home_____Work_____Cell_____

Preferred Contact Number_____Email_____

Street Address_____City_____

State_____Zip Code_____ Occupation/Employer or School_____

What is your Ethnicity? White_____African-American_____Hispanic_____Asian_____

Native American_____Biracial/Multiracial_____ Other, Please Specify_____

What is your religious preference, if any?_____

Spouse or Significant Other (if Relationship Therapy)

Spouse or Significant Other Name_____ Birth Date_____

Social Security Number_____ Gender M_____F_____

Phone Number(s) Home_____Work_____Cell_____

Preferred Contact Number_____Email_____

Street Address_____City_____

State_____Zip Code_____ Occupation/Employer or School_____

What is your Ethnicity? White_____African-American_____Hispanic_____Asian_____

Native American_____Biracial/Multiracial_____ Other, Please Specify_____

What is your religious preference, if any?_____

Parent or Legal Guardian (if Child Therapy)

Father's Name_____Responsible Party?_____Yes_____No

Social Security Number_____Gender M_____F_____DOB:_____

Phone Number(s) Home_____Work_____Cell_____

Preferred Contact Number_____Email_____

Street Address_____City_____

State_____Zip Code_____ Occupation/Employer or School_____

Client Name_____Parent of Legal Guardian (if Child Therapy) cont.

Mother's Name_____Responsible Party?_____Yes_____No

Social Security Number_____Gender M_____F_____DOB:_____

Phone Number(s) Home_____Work_____Cell_____

Preferred Contact Number_____Email_____

Street Address_____City_____

State_____Zip Code_____ Occupation/Employer or School_____

If you have other family members, please list:

Name_____DOB_____Gender_____Relation to Clt_____

Name_____DOB_____Gender_____Relation to Clt_____

Name_____DOB_____Gender_____Relation to Clt_____

Name_____DOB_____Gender_____Relation to Clt_____

Has client had any previous therapy/counseling experience(s)?_____If so, please describe_____

_____

How did you hear about us?_____

Who can be contacted in case of an emergency? Name_____Relationship to Client_____

Address_____Phone #_____

Briefly state your reason(s) for seeking therapy at this time_____

_____

Please list any past (or) current problems with chemical dependency (i.e., alcohol, drugs, etc.) in your family_____

_____

MEDICAL INFORMATION: Family Physician Name_____Phone Number_____

Address_____

Is your physician aware of the problems for which you are now seeking services?_____

Please list any health or medical problems within the last five years_____

_____

Please list any medications, prescribed or otherwise_____

_____

Please list any allergies_____

_____