THE THUSONG
A Place of Help

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 # _____ Gender: M___ F ___
Phone #(s) Home: _____ Work _____
Cell: _____
Address _____
Email: _____
Occupation/Employer or School _____
What is your ethnicity? White__ Black__ Hispanic__ Asian__
American (Indian, Eskimo, Aleut) __ Biracial/Multiracial __
Other, Please Specify_____
What is your religious preference, in any? _____

Parent or Legal Guardian

Father's Name: _____
Responsible Party? __Yes__No Social Security#____-___-_____
Birth Date _____Phone#(s) Home: _____
Work: _____ Cell: _____
Address _____
Email: _____
Occupation/Employer or School _____
Mother's Name: _____
Responsible Party? __Yes__No Social Security#____-___-_____
Birth Date _____ Phone#(s) Home: _____
Work: _____ Cell: _____
Address_____
Email: _____
Occupation/Employer or School_____
If you have other family members, please list:

1. Name: _____ Age: __ Gender __ Relation ___
2. Name: _____ Age: __ Gender __ Relation ___
3. Name: _____ Age: __ Gender __ Relation ___
4. Name: _____ Age: __ Gender __ Relation ___

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Client Name _____

Has client had any previous therapy/counseling experience(s)? Yes/No. If so, please describe: _____

_____

How did you hear about me? _____

Please list any past or current problems with chemical dependency (i.e., alcohol, drugs, etc.): _____

_____

Who can be contacted in case of an emergency?

Name: _____Relation to Client _____

Address: _____

Phone Number: _____

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

_____

_____

_____

MEDICAL INFORATION:

Family Physician Name: _____

Phone number: _____

Address: _____

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

Please list any health or medical problems within the last five years.

_____

_____

Please list any medicines, prescribed or otherwise.

_____

_____

Please list any allergies.

_____

_____