



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: _____ (please print)

Social Security Number: _____

Gender: _____ Age: _____ Date of Birth: ____/____/____

Current Address: _____

Email: _____

Occupation/Employer/School: _____ Grade: _____

Race: _____ Ethnicity: _____

What is your religious preference, if any? _____

Have you had any previous therapy/counseling experience(s)? Yes _____ No _____

If yes, 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: _____



Address: _____

Phone Number: _____

Briefly state your reason(s) for seeking therapy currently:

Medical Information:

Family Physician Name: _____

Phone Number: _____

Address: _____

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

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

Please list any medicines, prescribed or otherwise

Please list any allergies.
