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? ____

Parent or Legal Guardian

Parent: ____ Mother / Father / Guardian
(last name) (first name)

Responsible Party? ____Y ______N Social Security # __________-___________-__________
Birth Date________________________________Phone #(s) Home_________________________
Work:___________________________________Cell: ____________________________________
Address: ____
Occupation/Employer or School ____

Parent: ____ Mother / Father / Guardian
(last name) (first name)

Responsible Party? ____Y ______N Social Security # __________-___________-__________
Birth Date________________________________Phone #(s) Home_________________________
Work:___________________________________Cell: ____________________________________

Address: ____
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______________________________________

Has client 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.
____