THE THUSONG

Client Registration Form (Child/Adolescent)

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: ____/____/____

Name of person completing form: _____

Relationship to Child: _____ Today's Date: ____/____/____

Current address:_____

_____

Occupation/Employer/School: _____Grade: _____

Race: _____ Ethnicity: _____

What is your religious preference, if any? _____

28 South Tollgate Road, Owings Mills, MD, 21117 [o] 410.902.5940 [f]410.902.5941 [c] 443.739.4429

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 _____
Parent relationship: ___ partners ___ married ___ separated ___ divorced ___ widowed

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.

_____