
# CLIENT REGISTRATION FORM

DATE:_____

**FOR OFFICE USE ONLY**
Client #: _____
Therapist #:_____
Insurance:_____
EAP:_____
Diagnosis:_____

Name: _____ Name You Prefer? _____
(Last) (First)
Mailing Address: _____
**CITY**_____ **STATE**_____ **ZIP CODE + 4** _____ + _____

Date of Birth: ___ -___ -___ Age:____ Gender: □ Female □ Male
Vocation/Profession: _____ Employer:_____
Religious Denomination/Spiritual Preference:_____
Birthplace (country/state): _____
Relationship Status: □ Single □ Exclusive Relationship □ Married □ Separated □ Divorced □ Widowed

Home Phone: _____ Leave message? □ Yes □ No
Cell Phone: _____ Leave message? □ Yes □ No
Email Address: _____ Leave message? □ Yes □ No

Emergency Contact: _____ Telephone: _____
Relationship to You: _____

**—Please Answer The Following Questions—**

Please briefly describe the concerns that bring you to counseling at this time: _____
_____

Please share what you hope to achieve or gain through counseling: _____
_____

Have you been in counseling before? Yes___ No___ If yes, please share the reason you sought counseling, the duration, and outcome. _____
_____
_____
_____

## Additional Questions

Do you use alcohol? □ No □ Yes If yes, □ Daily □ 2-3 times weekly □ few times monthly
Do you use tobacco products? □ No □ Yes If yes, □ Daily □ 2-3 times weekly □ few times monthly
Do you use other drugs? □ No □ Yes If yes, □ Daily □ 2-3 times weekly □ few times monthly
Do you sleep well? (7 - 8hrs nightly) □ No □ Yes Concerned?_____
How is your appetite? □ Great □ Good □ Fair □ Poor Concerned?_____
How is your energy level? □ Great □ Good □ Fair □ Poor Concerned?_____
How is your overall physical health? □ Great □ Good □ Fair □ Poor Concerned?_____


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**Please Consider The Following Questions (continued)**

Are you currently taking psychotropic/medications for mental illness? NO_____ YES____ (If so please list)

| | Medication | Dosage/Frequency | PRESCRIBING PHYSICIAN |
|---|---|---|---|
| (1) | _____ | _____ | _____ |
| (2) | _____ | _____ | _____ |
| (3) | _____ | _____ | _____ |

Have you ever been hospitalized for mental health or psychiatric reasons? NO_____ YES_____ (If so please list)

| | Hospital | Month/Year | Diagnosis |
|---|---|---|---|
| (1) | _____ | _____ | _____ |
| (2) | _____ | _____ | _____ |

**Please complete the following IF YOU ARE registering a minor (17 years of age or younger)**

## Parents

| Name | Age | Lives in home w/ child? |
|---|---|---|
| _____ (Bio___/Cus__) | _____ | N or Y (circle one) |
| _____ (Bio___/Cus__) | _____ | N or Y (circle one) |
| _____ (Bio___/Cus__) | _____ | N or Y (circle one) |
| _____ (Bio___/Cus__) | _____ | N or Y (circle one) |

## Siblings

| Name | Age | Lives in home w/ child? |
|---|---|---|
| _____ | _____ | N or Y (circle one) |
| _____ | _____ | N or Y (circle one) |
| _____ | _____ | N or Y (circle one) |
| _____ | _____ | N or Y (circle one) |

## Others in Household

| Name | Age | Relation (if any) |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Comments/Additional Important Info: _____

_____

_____

_____


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