Client Registration Form

Today's date:	Therapist:

CLIENT INFORMATION

Last name:	First name:	Middle name:	Date of birth:	Age:	Social Security Number

Address:	PO Box/Apt. no:	City:	State:	Zip code:

Occupation:	Employer:	Length at job:	Email address:

Work phone no.:	Preferred way to be contacted:	Relationship status:
Cell phone no.:	Can I leave a message?: Yes No Can I send you a text?: Yes	Single Married ❑ Divorced Widowed ❑ Separated ❑ Cohabitating partner !Nongcohabitating partner !Other_____ Name of partner/wife/husband:
Home phone no.:	Insurance:	
Racial/ Ethnic Origin: Advance Directive:	Co-payment or Self Pay:	Name and Ages of Children

Primary care physician:	Primary care physician phone no.:	Last visit:	Length of time with PCP:

Have you been in therapy before? If yes, with who?:	Do you have a psychiatrist? If yes, who?	Psychiatrist's phone no.:

Medications (prescription and non, vitamins, supplements, herbs) : Drug: Dose: Time(s):	Substance Usage:
1. 2. 3.	1. 2. 3.

IN CASE OF EMERGENCY

Name a local friend or relative (please have one not living with you):	Relationship:	Phone no.:
1.		
2.		

Suicidal:

Homicidal:

Past: