Print Form

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Client Registration Form

Date_____

_____ _____
Client Name Date of Birth

_____
Address (with city, state and zip code)

_____ _____ _____
Home phone Business phone Mobile phone
Permission to call? Y N Permission to call? Y N Permission to call? Y N
Permission to leave message? Y N Permission to leave message? Y N Permission to leave message? Y N

Health Information:

_____
Significant present or previous health problems

_____
Medications Client is currently taking (and dosage)

_____
Primary care physician (or Group) Phone no. Fax no.

_____

When were you last examined by a physician? _____

Have you ever received psychiatric treatment, counseling, or family counseling before? Yes No

_____
When For how long?

_____
Psychiatrist/Therapist name Phone no. Fax no.

Emergency Contact:

_____
Name Relationship to Client Phone no.

_____
Address

Please check the issues, which are affecting you:

- ☐ Afraid or anxious
- ☐ Depressed
- ☐ Recurrent thoughts or actions
- ☐ Sleep problems
- ☐ Shyness
- ☐ Lacks self-control
- ☐ Hyperactive
- ☐ Learning problems
- ☐ Easily distracted
- ☐ Wants attention from others all the time
- ☐ Feeling Sad
- ☐ Physical abuse
- ☐ Seems to hear or see things others can't
- ☐ Feeling hopeless
- ☐ Nightmares
- ☐ Lack of appetite
- ☐ Isolation
- ☐ Stress
- ☐ Overeating
- ☐ Poor self-esteem
- ☐ Tearfulness
- ☐ Pulls out hair
- ☐ Emotional abuse
- ☐ Has rituals
- ☐ Unhappiness
- ☐ Hurts self/Cutting
- ☐ Anger or irritability
- ☐ Defiant to authority
- ☐ Mood Swings
- ☐ Lacks motivation
- ☐ Can't concentrate
- ☐ Impulsiveness
- ☐ Nail Biting
- ☐ Lying
- ☐ Sexual abuse
- ☐ Feels empty
- ☐ Suicidal Thoughts
- ☐ Doesn't talk
- ☐ Fights with others
- ☐ Worries all the time
- ☐ Alcohol or drug use
- ☐ Argues with others
- ☐ Stealing
- ☐ Seizures
- ☐ Stubborn
- ☐ Loss of appetite
- ☐ Destroys things
- ☐ Can't pay attention

Briefly describe your reasons for seeking counseling at this time:

_____

_____

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