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NEW CLIENT REGISTRATION

Date: _____

YOUR NAME: _____ Social Security Number: _____ - _____ - _____

Date of birth: ____/____/____ Relationship status: _____ Height: ____' ____" Weight: _____

Address: _____ City: _____ Zip: _____

Home Phone: (____) _____ Work: (____) _____ Cell Phone: (____) _____ Other: (____) _____

E-mail (print neatly!): _____ Alternate e-mail: _____

Occupation: _____ If employed, employer name: _____

If in relationship, how long? _____ Previously married? _____ If so, how often, and how long? _____

SPOUSE OR SIGNIFICANT OTHER (complete even if s/he is not participating in therapy)

Name: _____ Social Security Number: _____ - _____ - _____

Date of birth: ____/____/____ Relationship status: _____ Height: ____' ____" Weight: _____

Address (if not living with you): _____ City: _____ Zip: _____

Home Phone: (____) _____ Work: (____) _____ Cell Phone: (____) _____ Other: (____) _____

E-mail: _____ Alternate e-mail: _____

Occupation: _____ If employed, employer name: _____

Previously married? _____ If so, how often, and how long? _____

Who else lives in your home? Name _____ Age: _____ Relationship: _____

Name _____ Age: _____ Relationship: _____

Name _____ Age: _____ Relationship: _____

Name _____ Age: _____ Relationship: _____

Any children who live outside the home? (give names and ages) _____

Insurance Plan: _____ **Full Name of primary insured:** _____

If primary insured is not you, give their date of birth: ____/____/____ **and their employer:** _____

Emergency Contact (not partner): _____ Phone: (____) _____ Relationship: _____

Primary Doctor: _____ Phone: (____) _____

Doctor's address: _____ City: _____

Psychiatrist (if any): _____ Phone: (____) _____

Psychiatrist's address: _____ City: _____

Health Issues/Allergies: _____

Medications and Over-the-Counter Drugs taken regularly (include dosages and why you take them): _____

Alcohol: Average number of drinks per week: _____ Average number of drinks when you drink: _____

Marijuana / other non-prescription drugs (drug you use, how much use, how often): _____

Has anyone ever been concerned about your alcohol or drug use? _____ If so, who? _____

Cigarettes: Average use per day: _____ Desire to quit? _____

Who referred you to my practice? _____ **Did you look at my website before coming?** _____

Word or sentence to describe your life or how you feel: _____