NEW CLIENT REGISTRATION

Date: _______________ How did you find our practice? _______________________________________

What is the name of the person you are seeking therapy for? ___________________________________

Your relationship to this person: SELF PARENT/CAREGIVER OTHER: ___________________

CLIENT INFORMATION (Person who will be seen for therapy)

Client Name: ____ Date of Birth: ___________________

Social Security Number: _____________________ Gender: ____________________________________

Address: ____

Home Phone: __________________ Cell Phone: ________________ Work Phone: ________________

Email: ____________________________________ Best Way to Contact: _________________________

FOR ADULTS: Occupation: ________________________Employer: ______________________________

FOR CHILDREN: School: ____ Grade: _______________

FOR ADULT THERAPY: SPOUSE OR SIGNIFICANT OTHER (If Applicable):

Name: ____ Date of Birth: ___________________

Gender: ___________________ Relationship Status: ____

Address: ____

Best Way to Contact (home, cell, work, or email): ____

[ ] Ok to contact with my permission [ ] Do not Contact

Occupation (if applicable): ____

Employer: ____

FOR CHILD THERAPY: PARENT/CAREGIVER INFORMATION (Person Legally Responsible for the child)

Parent/Caregiver Name: ____________________________________ Date of Birth: ________________

SSN: ______________________ Gender: ___________________ Relationship: ____________________

Address: ____

Home Phone: __________________ Cell Phone: ________________ Work Phone: ________________

Email: ____________________________________ Best Way to Contact: _________________________

Occupation (if applicable): ____

Employer: ____

WHO ELSE LIVES IN YOUR HOME? (Name, Age, Relationship to Client)

Name	Age	Relationship

INSURANCE INFORMATION: (Please provide a copy of the front and back of your insurance card.)

Insurance Plan: _______________________________ Insurance Phone Number __________________

ID# ________________________ Group# ___________ Employer: _______________________________

Name of Primary Insured: _________________________________ Date of Birth: __________________

Do you have secondary insurance? Yes (please fill information below) No

Insurance Plan: _______________________________ Insurance Phone Number __________________

ID# ________________________ Group# ___________ Employer: _______________________________

Name of Primary Insured: _________________________________ Date of Birth: __________________

EMERGENCY CONTACT (not your spouse/partner):

Name: ______________________________ Phone: ___________________ Relationship: ________________

CLIENT'S MEDICAL AND PSYCHOTHERAPY HISTORY:

Previous therapy history:

Agency/Therapist's Name	Phone/Location (City/State)	Dates (month/year)

Primary Care Physician: ___________________________________ Phone: ___________________________

Psychiatrist (if any): _______________________________________ Phone: ___________________________

Other Providers (e.g., occupational therapist, speech therapist, psychologist, etc.):

Provider Name: ____ Phone: ___________________________

Provider Name: ____ Phone: ___________________________

Health Issues or Allergies: ____

____

Medications (include dosage any why you take them): ____

____

Has anyone ever been concerned about your alcohol or drug use? YES NO

If so, why? ____

THERAPY GOALS:

What are you seeking help with? Give a brief description of your primary concern.

____

____

What do you hope to achieve or gain with therapy?

____

Thank you for taking the time to complete this form. See you soon!