CLIENT REGISTRATION AND HISTORY

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Client Information Today's date:_____

Name: _____ Date of Birth: _____ Age:_____
Last First MI

Address: _____
Street City State Zip

Gender identification: _____

Primary Phone Number: _____ Alt. Phone: _____
Ok to leave a message? ❑Yes ❑No OK to leave a Message ? ❑Yes ❑No

Email:_____ Message OK? ❑Yes ❑No

Are you currently employed? ❑Yes ❑No

Employer: _____ Position: _____

Referred by: _____

Emergency Contact: _____ (Identify a person you authorize the therapist to contact in case of an emergency)
Emergency Contact's Phone Number: _____
Emergency Contact's Relationship to You: _____

Presenting Problem: In your own words, describe why you are seeking counseling:

_____
_____
_____

Did a specific event or situation lead to this session? ❑Yes ❑No Comments: _____

_____
_____
_____

Goals of Therapy: In your own words, describe your expectations or goals for your therapy:

_____
_____
_____

YOUR BACKGROUND AND HISTORY:

What is your education level: _____ Current Occupation: _____
Are you satisfied with your job/career/occupation? ❑ Yes ❑ No Comment:
_____

Ethnic background: _____ Language spoken in your home? _____
Religious/Spiritual Tradition: _____

Your Marital/Significant Relationship Status (Check all that apply): Years together/married: _____
❑ Married ❑ Living together ❑ Never married ❑ Divorced ❑ Separated ❑ Other _____
Please identify the problems you see in the relationship: _____
_____
_____

Spouse/Partner Name: _____ Occupation: _____
Satisfied with job? ❑Yes ❑No Comment: _____

Children
Name: _____ Gender:_____ Age:_____
Name: _____ Gender:_____ Age:_____
Name: _____ Gender:_____ Age:_____
Name: _____ Gender:_____ Age:_____

Mother's Name: _____ Stepmother? ❑Yes ❑No
Occupation: _____ Highest level of education: _____
Father's Name: _____ Stepfather? ❑Yes ❑No
Occupation: _____ Highest level of education: _____

Siblings
Name: _____ Gender:_____ Age:_____
Name: _____ Gender:_____ Age:_____
Name: _____ Gender:_____ Age:_____
Name: _____ Gender:_____ Age:_____

With whom were you raised? (Check all that apply)
❑Biological parents ❑Parent and step-parent ❑Foster parents ❑Single parent
❑Adoptive parents ❑Relatives ❑Institution ❑Legal guardian ❑Other: _____

Marital Status of Parents (Check all that apply) Years Married: _____
❑ Married ❑ Living together ❑ Never married ❑ Divorced ❑ Separated
Comments: _____

Please list any major medical conditions in your family: _____
_____
Your medical conditions or health issues: _____
_____
_____
Current Physician: _____ Phone #: (_____) _____ - _____
Date of most recent visit: _____ Reason: _____

Medications you take:
❑ None, I do not take prescription medication at this time
Medication: _____ Medication: _____
Medication: _____ Medication: _____
Please describe history of other serious illness or injuries: _____

_____

Is there any family history of treatment for psychological/psychiatric conditions? ❑ Yes ❑ No
Comments: _____

Have you had previous treatment, counseling, or psychotherapy? ❑Yes ❑No
With whom and when: _____
_____

Have you ever felt suicidal? ❑ Yes ❑ No Do you feel that way now? ❑ Yes ❑ No Comments:
_____
_____

Are you involved in any legal proceedings? ❑Yes ❑No Comments:
_____
_____

Have you ever been arrested? ❑ Yes ❑ No Have you ever been convicted of a crime? ❑ Yes ❑ No
Comments: _____

Do you drink alcohol? ❑ Yes ❑ No What kind? _____ Amount & Frequency: _____
Do you use tobacco? ❑ Yes ❑ No What kind? _____ Amount & Frequency: _____
Do you use other drugs? ❑ Yes ❑ No What kind? _____ Amount & Frequency: _____
Do you have a history of alcohol or substance abuse, dependency, and/or addiction? ❑Yes ❑No Comments: _____
_____
_____

Do you (or those close to you) have any concerns about your current alcohol or other substance use? ❑Yes ❑No
Comments: _____
_____
_____

Do you have a history of an eating disorder (anorexia, bulimia, and/or compulsive restricting or overeating)? ❑Yes ❑No
Comments: _____
_____

Do you (or those close to you) have concerns about any of your other behavior patterns (e.g., gambling, sex, pornography, shopping, spending, computers, exercise, hoarding, codependence, etc.)? ❑Yes ❑No
Comments: _____
_____
_____

Have you been a victim, past or present, of physical or sexual abuse/assault? ❑ Yes ❑ No
Comments: _____
_____

Please describe your sleep patterns (average hours of sleep per night, loss of sleep, excessive sleeping, history of sleep apnea, etc.):
_____

Nutritional habits: ___poor ___fair ___good ___excellent
Exercise habits: ___poor ___fair ___good ___excellent

Please describe your social support system: _____
_____

What is your current living situation? _____
_____

Is there anything that you would like to add? Is there anything important that has not already been asked about?
_____
_____
_____
_____

I UNDERSTAND THAT OPEN AND HONEST DISCLOSURE IS CRITICAL TO THE THERAPEUTIC PROCESS, AND I COMMIT TO PRACTICING OPENNESS AND HONESTY IN ALL ASPECTS OF MY THERAPY. I AFFIRM THAT THE INFORMATION I HAVE PROIVIDED ON THIS FORM IS TRUE, CORRECT, HONEST, AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND ABILITY.

_____ _____
Client Signature Date

A COPY OF THIS FORM IS AVAILABLE UPON REQUEST