Client Registration Form

Personal Information

Name _____

Address _____

City, State, Zip _____

Best Phone number: _____

Year of Birth: _____

Preferred Pronouns: _____

Emergency Contact name and best email/phone number:

_____

Clinical Information

Medications currently taken (type, dosing, duration):

Current or Previous counseling (please include dates):

Please check any of the following that apply:

History of high blood pressure: _____
History of head injuries: _____
History of heart conditions: _____

Which of the following are of concern to you at this time:

Substance use/abuse	_____	Health problems	_____
Thoughts of suicide	_____	Work problems	_____
Current abuse/violence	_____	Children/parenting	_____
Death of a loved one	_____	Financial worries	_____
Past abuse/violence	_____	Legal issues	_____
Eating Disorder	_____	Anxiety	_____
Cognitive Functioning/memory issues	_____	Self Esteem	_____

Traumatic incident (e.g., sexual assault, natural disaster, accident, etc. _____

Any previous diagnosis you have been given that you know:_____

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