CLIENT REGISTRATION AND HISTORY

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: _____ **Phone:** _____

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: _____

_____
_____
_____
_____

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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: _____

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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: _____

_____

What issues did you address?

_____

_____

_____

_____

Would you be willing to give permission for you prior therapist to be contacted? ____ Yes ____ No

Have you ever felt suicidal? ❑ Yes ❑ No Do you feel that way now? ❑ Yes ❑ No If so do you have a plan or intent?

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: _____

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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 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 have concerns about any 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

What is your current living situation?

_____

_____

What does your social support system include? (family, friends, church, 12 step groups, etc.)

_____

_____

_____

What are your strengths? (List minimum of 3)

_____

_____

_____

Which of your accomplishments are you most proud of? (List a minimum of 3)

_____

_____

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_____

What do you like most about yourself ? (List a minimum of 3)

_____
_____
_____

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

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