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: ___________________________________
Is it Ok to leave a message? ❑Yes ❑No **Is it OK to leave a Message? ❑Yes ❑No**

Email:____
Is contact by email 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: _________________________________

____
____
____
____

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**: __________________________________

Have you ever attempted suicide? ___ Yes ___No If so when?____

Have you ever felt suicidal? ❑ Yes ❑ No If so when is the last time you felt this way?_________________________________

Do you feel that way now? ❑ Yes ❑ No If so do you have a plan or intent? ___Yes ___No If so please explain:

____

____

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 psychological/psychiatric conditions? ❑ Yes ❑ No

Comments: ____

Have you had previous treatment, counseling, or psychotherapy? ❑Yes ❑No

If yes, 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

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 have any concerns about your current alcohol or other substance use? ❑Yes ❑No Comments: _____________________

____

____

Were alcohol or substances used by anyone in your childhood home? ___Yes ___No
If so what was used? __________________________ By whom?____
If so how often (daily, weekly, monthly)?____

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

____

Were there any addictions or compulsive behaviors in your home in childhood? ___Yes ___No
If yes, what were they and by whom? ____

Do you have concerns about any other behavior patterns (e.g., gambling, sex, pornography, shopping, spending, computers, exercise, hoarding, codependence, work, 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)

____
____
____

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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