Family Outreach & Counseling Center (FOCC)
200 West Sugar Creek Rd.
Charlotte, NC 28213
Phone/Fax:704-509-9917

New Client Registration

Name: _____ **Social Security Number**: _____-_____-_____
Preferred Name: _____ **Pronouns:** _____
Date of birth: _____/_____/_____ **Relationship status:** _____
Address: _____ **City:** _____ **Zip:** _____
Home Phone: (_____) _____ **Work:** (_____) _____
Cell Phone: (_____) _____ **Other:** (_____) _____
E-mail: _____ **Alternate contact:** _____
Occupation: _____ **Employer:** _____

Insurance Information

Insurance Provider _____**Group #** _____ **Insurer:** _____
Insurer's Date of Birth: _____/_____/_____ **Insurer's Employer**: _____

Emergency Contact

Name: _____ **Phone:**(_____) _____ **Relationship:** _____

Medical History:

Physician: _____ **Phone:** (_____) _____
Address: _____ **City:** _____ **Zip:** _____
Psychiatrist: _____ **Phone:** (_____) _____
Address: _____ **City:** _____**Zip:** _____
Health/Allergies: _____
_____
Medications/Over-the-Counter Drugs taken regularly (include dosages and why you take them): _____
_____
Alcohol: Average number of drinks per week_____ Average number of drinks when you drink: _____
Marijuana / other non-prescription drugs (how much/ how often): _____
Has anyone ever been concerned about your alcohol or drug use? _____ If so, who? _____
Cigarettes: Average use per day: _____ Desire to quit? _____
Referral Source? _____ **How did you hear about FOCC?** _____
Describe how you and feeling and what you would like to work on?
_____
_____
_____
_____
_____
_____
_____