Marcia Pritchard, MA, LPC
Client Registration

Today's Date:_____

Name:_____Date of Birth:_____
(client's name)

Name:_____Date of Birth:_____
(couple's client) or (legal guardian of client)

Name:_____Date of Birth:_____
(other legal guardian of client)

Relationship Status: Single ___ Engaged___ Married ___ Widowed___ Divorced ___ Separated

_____

Address:_____

City:_____ State:_____Zip:_____

Cell Phone:_____ Home/Work Phone:_____
Therapist may/may not (please circle) leave messages at cell, home, or work phone number.

Email:_____

Occupation:_____Client Employer:_____

Emergency Contact:_____Phone:_____

List any significant health problems:_____

Medications: Yes No If yes, please list_____

Physician's Name _____ Phone:_____

Would you like your therapist to be in communication with your physician: Yes No

Previously received counseling services: Yes No If yes, list dates and reasons: _____

_____

Primary reason you are seeking counseling now:_____

_____

Current symptoms are you experiencing:____