CONNECTING STEPS COUNSELING

NEW CLIENT REGISTRATION

Today's Date: _____

Client Information

Full Legal Name: _____ Preferred Name: _____

Date of Birth: _____ Age: _____ Gender: _____ Marital Status: _____

Mailing Address: _____ Social Security No.: _____

_____

Phone No.: _____ Email: _____ Leave Msg: _____

Employer/School: _____ Type of Work/Grade: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Information

Person Responsible for Billing: _____ Relationship: ☐ Self ☐ Spouse ☐ Parent

Subscriber's Name: _____ Date of Birth: _____

Subscriber's Employer: _____ Insurance Company: _____

ID No.: _____ Group No.: _____

Health History Form

Health Problems (please list major illnesses or conditions within the last year): _____

_____

_____

Psychiatrist/ARNP: _____ Contact No.: _____

Medications (if any):

Name	Dose	Reason for Taking

15600 Redmond Way, Ste 201, Redmond WA 98052
Phone: 425.589.9900 E-mail: info@connectingstepscounseling.com

CONNECTING STEPS COUNSELING

Areas of Concern

☐ ADD/ADHD	☐ Communication	☐ School Issues
☐ Alcohol/Drug Use	☐ Depression	☐ Social Problems
☐ Anxiety	☐ Family Conflict	☐ Suicide Ideation
☐ Behavioral Issues	☐ Impulse Control	☐ Work Issues
☐ Bipolar Disorder	☐ Relationship Issues	☐ Other: _____

Counseling Goals

Have you had previous counseling? ☐Yes ☐No
If yes, when and for how long? _____

Previous Diagnosis: _____

What specific event(s) or experiences(s) have led you to seek counseling now?

_____
_____
_____

What are you hoping to gain from counseling?

_____
_____
_____

Anything else you feel I should know:

_____
_____

_____ _____
Signature of Client (13yrs old and above) Date

_____ _____
Signature of Parent/Guardian (if a minor) Date

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