CLIENT REGISTRATION

Today's Date_____
Client Name_____Date of Birth_____Age_____
Best Number to contact you_____May I leave voice mail? ____ Email_____
Address_____
SS#_____Employer/School_____Occupation_____
Grade/Length of Employment _____If Client is a minor, your name and relationship to Client_____ Marital Status_____Duration of current relationship_____Previous Marriages?_____Children?____ If yes, how many?_____Names and ages_____
_____Where do they live? _____
Other persons/pets living with you_____
Current Health Problems_____
Current Medications_____
Primary Physician/Psychiatrist Name and Number_____
Previous Counseling Dates and Names_____
_____Was it helpful?_____
Who referred you?_____ May I thank them?_____
Briefly, what brings you to counseling at this time? _____
_____
_____

What kinds of symptoms or issues have motivated you to come to counseling? (Circle all that apply.)
Addictions Anger Anxiety Concentration problems Depressed Mood Decreased Energy Grief Guilt Hopelessness Hyperactive Irritability Moody Obsessions/Compulsions Panic Attacks Self-injurious Behavior Sexual Problems Sleep Problems Weight Changes Eating Problems Hyperactivity Nightmares Flashbacks Emotionally Numb Physical Symptoms and Sensations Communication problems Relationship Issues Family Issues Difficulty Trusting Self-Esteem Life Transitions Personal Growth Parenting Issues, Job Problems Other (describe)_____
_____

History of significant life events, such as, losses, divorce, childhood abuse, combat, separations, abandonment, domestic violence, infidelity, trauma, accident, broken heart, arrest, imprisonment other (please describe)_____
(circle all that apply) **Please share whatever you'd like about any circled**
_____
_____
_____

Ever experienced suicidal thoughts or feelings?_____ If yes, when?_____

Current Stressors (Circle all that apply)
Marriage Peers/friendships Family Financial Disability Job Jeopardy Job Performance Educational Legal Housing Healthcare Recent Trauma Old Trauma Other (please describe)_____

Ways you cope with Stress (e.g. drink, exercise, pray, eat, sleep, smoke, etc.)_____
_____

Do you drink alcohol? ____ If so, what?_____, how much? _____
How often?_____ **What other substances are you currently using?**_____ **Have you participated in Recovery Activities?**_____If yes, when and where?_____
current involvement in Self Help/Support Group (e.g. AA, NA Alanon)_____

Strengths and Supports (e.g. good friends, faith, healthy lifestyle)_____
_____

Please identify one goal you would like to accomplish as a result of Counseling._____
_____

Please rate your **current Overall level of functioning**.
Poor____ Below Average___Average___Above Average____ Excellent____

Please rate your **current Level Functioning in Your Personal Life**
Poor____Below Average____Average___Above Average____Excellent____

Please rate your **current Level of Functioning in Your Work/School Life.**
Poor____Below Average____Average____Above Average___Excellent____

Please rate your **current Lifestyle Habits and Practices, (**e.g. diet, exercise, positive thinking).
Poor____Below Average____Average____Above Average____Excellent____

Emergency Contact: Name_____Phone_____
Relationship_____Person Responsible for Payment_____

Other information that might be important for me to know._____
_____

_____ _____
Your Signature Today's Date