Healing Waters Counseling Center
PATIENT REGISTRATION & ASSESSMENT

Shaded area to be completed by counseling center staff:

Intake DATE: _____

CLIENT INFORMATION - for patients 18 years old or older

Date: _____

Referral Source: _____ Referral's Phone (if applicable): _____

Full Name: _____ SSN: ___-___-____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Sex: ☐Male / ☐Female Birth Date: _____ Age: _____ Ethnic/Racial Group: _____

☐Single / ☐Married / ☐Widowed / ☐Divorced Family Size: _____ Number of Children: _____

Religion: _____ Church Status: Active / Inactive

Education *(circle last completed)*: Grade School / High School / College / Graduate School / Grad. School +

Emergency Contact: _____ Emergency Phone: _____

Employer: _____ Occupation: _____ Work Phone: _____

Annual Income *(circle one)*: under $20,000 / $20,000+ / $30,000+ / $50,000+ / $100,000+

Is this your first counseling experience? Yes / No

Reason for Referral: _____

Spouse/Partner Information

Spouse's Full Name: _____ SSN: ___-___-____ Birth Date: _____ Age: ____

Home Address: _____

Ethnic/Racial Group: _____ Religion: _____ Church Status: Active / Inactive

Home Phone: _____ Cell Phone: _____ Work Phone: _____

PARENT / GUARDIAN INFORMATION

Number of Children: _____ How many children currently live with you? _____

Ages _____

How many children do you have? _____ How many children does spouse/partner have? _____

How many children do you have together? _____

Signed: _____ Date: _____