

CLIENT REGISTRATION FORM - ADULT

Today's Date:						
Client Information						
First Name			Last Name			
Date of Birth						
Home phone number			Cell phone number			
Occupation			Highest level of education			
Emergency contact name			Relationship to you			
Phone number			Alternative phone number			
Who referred you?						
Please list all immediate family members. Please include name, relationship to you, age, location, and any mental illness.						
Name	Relationship	Age		Location	Mental Illness	
TWINE	Terminologia	7150		Booming	THE MAIN THINESS	

Medical History					
Are you currently taking medication?					
Yes No					
If yes, please list current medication names, dosages, and reason for taking.					
Please list any significant medical history, including chronic conditions, accident, major illnesses, surgeries, etc.).					
Please list any psychiatric diagnoses you have received in the past, including who diagnosed you and when.					
Please list any psychiatric treatment you have received in the past, including psychotherapy and hospitalizations. Include reasons, locations, and timeframe.					
Please list previous medications, when taken, for how long, and in what combinations (including past trials of medications for attention, anxiety, depression, etc.)					

Reasons for Seeking Treatment
Why are you seeking therapy now?
Describe your goals for therapy.
Is there any other information that you think would be helpful in working with you?