

**Client Registration Form**

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Sexual Orientation \_\_\_\_\_ Ethnic / cultural background \_\_\_\_\_

Native language \_\_\_\_\_ Preferred language for therapy \_\_\_\_\_

Profession and employment status \_\_\_\_\_

Name of employer \_\_\_\_\_

Home address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home / Cell phone \_\_\_\_\_ Is it okay to leave a message? \_\_\_\_\_

Email \_\_\_\_\_ Can I contact you by email? \_\_\_\_\_

Previous history of depression, anxiety, or other mental health issues? \_\_\_\_\_

Are you currently on medication: \_\_\_\_\_

If so, medications and dosage: \_\_\_\_\_

If so, who is the prescribing physician? \_\_\_\_\_

Person(s) to notify in case of any emergency

\_\_\_\_\_  
Name Phone number

Referral Information (the person who gave you the information to contact me)

\_\_\_\_\_  
Name Contact information

May I have your permission to thank this person for the referral? Yes \_\_\_\_\_ No \_\_\_\_\_

If referred by another clinician, would you like for us to communicate with one another?

Yes \_\_\_\_\_ No \_\_\_\_\_

Thank you for completing this form and congratulations for taking your first step towards your better health. Please feel free to discuss any aspect of your response with me during our meeting.

Thanks again!