REGISTRATION

New Client Registration

Client Information

Name

Date

Preferred Phone Number

☐ Home ☐ Work ☐ Other

Permission to leave detailed messages on this phone? ☐ Yes ☐ No

Address

Apartment

City

Zip

E – Mail

_______ / _______ / _______

Date of Birth

Gender:

☐ Male
☐ Female
☐ Trans - Circle Transman or Transwoman
☐ Other

Preferred Gender Identity

_______ – _______ – _______

Social Security Number

Relationship Status:

☐ Single
☐ Married / Partner
☐ Separated
☐ Divorced
☐ Widowed

REGISTRATION

New Client Registration

Healthcare Information

Referred by

Address | Phone Number

Current Therapist

Address | Phone Number

Primary Care Provider

Address | Phone Number

May we exchange information with your treating physicians to coordinate your care?

Therapist: ☐ Yes ☐ No   Primary Care: ☐ Yes ☐ No   OB/GYN: ☐ Yes ☐ No

Pharmacy

Address | Phone Number

Emergency Contact

Address | Phone Number

Person responsible for payment (if other than client) | Relationship to Client

Address | Phone Number

REGISTRATION

New Client Registration

Medical History

Previously diagnosed medical conditions:

Any history of head injury? ☐ Yes ☐ No

Allergies (indicate what sort of reaction to each medication):

Medications you are currently taking (continue on back if needed):

Psychiatric medications in the past (indicate if any were especially helpful or caused problems):