Adult Registration

FULL NAME ____ TODAY'S DATE ____________________

FIRST MI LAST

PREFERRED NAME: ____ DOB/AGE________________________

DEMOGRAPHICS

SS#/SIN ____ GENDER □Male □ Female □ Other:______________

Parent/Legal Parent/Legal Guardian (if under 18) ____

____

STREET/APT CITY STATE ZIP CODE

Primary No. (_______)-________-______________ (Message Ok □ Yes □ No) Prefer: □ Voice □Text □ Both

Email: ____ (Email Ok □ Yes □ No)

*Please note: Email correspondence is not considered to be a confidential medium of communication

Relationship Status: □ SINGLE □ MARRIED □ PARTNER(S) □ SEPARATED □ DIVORCED □ WIDOWED

How did you learn about us? Online/list site, referral/who, signage, other?_______________________________

REASON FOR THERAPY

Briefly describe your reason for seeking counseling services: ____

____

____

What do you hope to gain from therapy: ____

____

____

GENERAL & MENTAL HEALTH

MENTAL HEALTH

Please check any and ALL of the following areas in which you are experiencing problems:

□ Nervousness	□ Depression	□ Shyness	□ Sexual Problems
□ Suicidal Thoughts	□ Separation/Divorce	□ History of abuse/trauma	□ Finances
□ Frequent Drug Use	□ Frequent Alcohol Use	□ Friends	□ Anger
□ Sleep	□ Self-Control	□ Gambling	□ Unhappiness
□ Stress	□ Feeling fearful/anxious	□ Relaxation	□ Headaches
□ Tiredness	□ Legal Matters	□ Memory	□ Grief/Loss

□ Energy	□ Making Decisions	□ Spiritual Concerns	□ Loneliness
□ Inferiority Feelings	□ Concentration	□ Career Choices	□ Health Problems
□ Nightmares	□ Marriage	□ Children/Parenting	□ Work
□ Stomach Discomfort	□ Obsessions/Compulsions	□ Self Harm	□ Appetite

How long have you had the symptoms listed above? ____
How do you rate your distress: □ 1 (low) □ 2 □ 3 □ 4 □ 5 (severe)

Any deterioration due to symptoms above: □ Work/School □ Relationships □ Erratic behavior/emotions
Please explain:
____
____
____

Are you seeing any other therapist? □ NO □ YES If yes, who? ______________________ #_______________
Do you have a psychiatrist? □ NO □ YES If yes, who? ____________________________ #_______________

Have you EVER received psychiatric help, psychiatric hospitalization, detox, substance abuse treatment or any counseling. ____
____
____
____

GENERAL HEALTH
How would you rate your current physical health? □ Poor □ Fair □ Good □ Very good

Emergency Contact

NAME	PHONE #	RELATIONSHIP

Primary Care Physician __________________________________ Phone____________________________
Location of PCP Office __________________________________ Date of Last Visit _____________________

List any & ALL medication(s) you are now taking, the amount and why you're taking it:
____
____
____
____

Within a week, how many times do you…

Activity	None	1 – 2 Days	3 - 4 days	5 - 6 days	Daily
Exercise					
Nicotine					

Alcohol/Amount					
Substances/what? Type, amount & How often					

What significant life changes or stressful events have you experienced within the past year?

____

____

FAMILY

List the people who live with you in your home:

NAME	AGE	RELATIONSHIP		NAME	AGE	RELATIONSHIP

Describe the relationship with people in your family: ____

____

____

Describe your religious/spiritual beliefs ____

____

Anyone in your family experience…

- Mental health concerns □ NO □ YES If yes, who? _______________________________________
- Substance Use concerns □ NO □ YES If yes, who? _______________________________________
- Suicide/suicide attempts □ NO □ YES If yes, who? _______________________________________
- Domestic Violence □ NO □ YES If yes, who? _______________________________________

EMPLOYMENT/EDUCATION

School _____________________________________ Grade ___________ or Graduated ______________

College ____ Degree _______________________________

Name of Employer ____ Position ________________________________

LEGAL HISTORY

Current or Past Involvement with the legal system (if Yes, please describe): □ NO □ YES

____

Have you ever been incarcerated? □ NO □ YES # of times: ________ Dates: __________________________

Are you on Probation/Parole? □ NO □ YES Name/Phone Number: ______________________________________

ADDITIONAL INFORMATION

List your strengths ____

____

____

List your limitations ____
____
____

Who is your support? ____
____

What do you enjoy & do for fun? ____
____