Registration Form

Information provided here is confidential. Please fill out this form and bring it to your first session.
If you need extra space to write, feel free to use the back of each page.

Date _____ Referred by _____

Name _____ _____ _____ Date of Birth_____
Last First Middle Initial

Address _____ _____ _____ _____
Number and Street City State Zip Code

E-mail: _____

Home Phone: _____ Cell Phone: _____

Marital Status: ☐ Married Date _____ ☐ Domestic Partnership Date _____

☐ Never Married ☐ Separated ☐ Divorced ☐ Widowed

☐ Previous marriage(s) Dates

HOUSEHOLD MEMBERS: _____ M ☐ F ☐ DATE OF BIRTH: _____
_____ M ☐ F ☐ DATE OF BIRTH: _____
_____ M ☐ F ☐ DATE OF BIRTH: _____

CHILDREN (not living with you) _____ M ☐ F ☐ DATE OF BIRTH: _____
_____ M ☐ F ☐ DATE OF BIRTH: _____

FAMILY OF ORIGIN:

FATHER: _____ DATE OF BIRTH: _____ DATE OF DEATH: _____

MOTHER: _____ DATE OF BIRTH: _____ DATE OF DEATH: _____

SIBLINGS: _____ M ☐ F ☐ DATE OF BIRTH: _____
_____ M ☐ F ☐ DATE OF BIRTH: _____
_____ M ☐ F ☐ DATE OF BIRTH: _____

Mental Health History

Have you previously used mental health services? ☐ No ☐ Yes Previous Therapist_____

Have you ever been prescribed psychiatric medication? ☐ No ☐ Yes

Name of medication(s)_____

Are you currently experiencing overwhelming sadness, grief or depression? ☐ No ☐ Yes

Are you currently experiencing anxiety, panic attacks or phobias? ☐ No ☐ Yes

How often do you drink alcohol? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

How often do you use recreational drugs? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

General Health Information

How would you rate your current physical health? ☐ Poor ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific health problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

Type of exercise _____ Duration _____

Family Mental Health History

Do any family members have a history of:

Condition			Family Member
Alcohol/Substance Abuse	Yes ☐	No ☐	_____
Anxiety	Yes ☐	No ☐	_____
Depression	Yes ☐	No ☐	_____
Domestic Violence	Yes ☐	No ☐	_____
Eating Disorders	Yes ☐	No ☐	_____
Obesity	Yes ☐	No ☐	_____
Obsessive Compulsive	Yes ☐	No ☐	_____
Schizophrenia	Yes ☐	No ☐	_____
Suicide Attempts	Yes ☐	No ☐	_____
Other _____	Yes ☐	No ☐	_____ __

Other Information:

_____

_____

_____

I acknowledge that I have received the HIPPA notice form.

Signature _____ Date: _____