ADULT CLIENT REGISTRATION FORM

Date: _____

Name: _____ DOB: _____ Age: ____ Gender: _____

Address: _____

Phone: _____ Email Address: _____

Employment/School: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Who do you live with? _____

Are you interested in involving family members in the treatment process? □ Yes □ No

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Who Referred You: _____

Reason for Your Visit: _____

_____

_____

_____

_____

Medical and Mental Health History

Do you have any acute or chronic medical conditions (e.g., asthma, diabetes, cancer) □ Yes □ No

If yes, please list the condition(s) and date of diagnosis: _____

_____

Current Medications: □ None □ Yes: _____

_____

Allergies: □ None □ Yes: _____

Have you participated in mental health services in the past? □ Yes □ No

If yes, please list most recent provider and any prior diagnoses: _____

_____