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CLIENT REGISTRATION

PLEASE PRINT CLEARLY

Today's Date: _____

This form requests information about you (or your child) that will help me design a treatment plan geared to your needs. I appreciated your time and effort in completing this form as accurately as possible. If you have any questions, please don't hesitate to discuss them with me. Thank you.

Client Name: _____ Birthdate: _____
Address: _____ Age: _____ SS#: _____
City, State, Zip: _____ Home Phone: () _____
Employer: _____ Work Phone: () _____
Cell Phone: _____ Email Address: _____

Emergency Contact:

Name: _____ Relation: _____ Phone: () _____

If client is a child:

Mother: _____ HM: () _____ WK: () _____

Father: _____ HM: () _____ WK: () _____

Relationship Status: Single Married/ Partnered Separated Divorced Widowed
Person responsible for payment: Self Other _____

Address: _____ SSN: _____

City/ State/ Zip: _____

Please list all persons living in your household:

| Name | Age | How Related |
|-------|-------|-------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Primary Care Physician: _____ Telephone: () _____

By whom were you referred? _____

PRIMARY INSURANCE INFORMATION

Name: _____

Insurance Name: _____

SSN: _____ DOB: _____

Employer: _____

Member #: _____

Policy/ Group #: _____

Insurance Phone #: () _____

History

Please describe your reason(s) for seeking treatment at this time (Include when the problem started)

Please list other health care professionals currently treating you: _____

Please list current health problems and any medications you are taking: _____

Please indicate past problems with a "P" and current with a "C":

| | | |
|--|---|--|
| <input type="checkbox"/> Abuse | <input type="checkbox"/> Eating or Weight Problems | <input type="checkbox"/> Manic Episodes |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Eliminating a Drug/Alcohol problem | <input type="checkbox"/> Marriage/ Relations |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Elimination of Another Habit | <input type="checkbox"/> Obsessions |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Family Conflicts | <input type="checkbox"/> Phobias/Fears |
| <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> LD/ADHD | <input type="checkbox"/> Sexuality/Sexual |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Legal Matters | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Trauma |

Please indicate how the problems are affecting the following areas of your life:

| | No Effect | Little Effect | Some Effect | Much Effect | Significant Effect | Not Applicable |
|-----------------------|-----------|---------------|-------------|-------------|--------------------|----------------|
| Marriage/Relationship | 1 | 2 | 3 | 4 | 5 | N/A |
| Family | 1 | 2 | 3 | 4 | 5 | N/A |
| Job/School | 1 | 2 | 3 | 4 | 5 | N/A |
| Performance | 1 | 2 | 3 | 4 | 5 | N/A |
| Friendships | 1 | 2 | 3 | 4 | 5 | N/A |
| Financial Situation | 1 | 2 | 3 | 4 | 5 | N/A |
| Physical Health | 1 | 2 | 3 | 4 | 5 | N/A |

Total _____

Have you ever received mental health or substance abuse treatment before? If yes, please describe:

| <u>Type of treatment</u> <u>(Inpatient/ Outpatient)</u> | <u>Provider Name</u> | <u>First Seen</u> | <u>Last Seen</u> |
|--|----------------------|-------------------|------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Is there anything else you feel is important for me to know?

Thank you,
Don Baker, MA LMHC
