New Client Registration

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Personal Information

Name: _____

Date of birth: _____

Gender identity: _____ Pronouns: _____

Racial/ethnic identity: _____

Address: _____

Phone number: _____ May I leave a message? Y N

Email address: _____ May I email you? Y N

How did you find my practice? _____

Emergency Contact

Name of emergency contact: _____ Relationship: _____

Home phone: _____ Work phone: _____

Please initial here to indicate that I may contact this person in case of an emergency: _____

Insurance Information

Name of insurance company: _____

Telephone number of insurance company: _____

Subscriber/ID #: _____ Group #: _____

Name of primary insured: _____ DOB: _____

Primary insured's address (if different than above): _____

Primary insured's phone number (if different than above): _____

Please initial here to indicate that I may submit claims to your insurance company: _____

Medical History

Please list any past or current major illnesses, surgeries, or other significant physical conditions.

Are you currently taking any medications or supplements? Y N

If yes, please list: _____

Please note any side effects: _____

Have you ever been hospitalized for any reason (i.e., psychiatric concerns, illness, accident, etc.)?

If yes, please list causes and dates: _____

Family History

	Living?	Age?	Any mental/physical illness; cause and date of death if applicable
Mother:	Y N	_____	_____
Father:	Y N	_____	_____
Sibling:	Y N	_____	_____
Sibling:	Y N	_____	_____
Sibling:	Y N	_____	_____
Child:	Y N	_____	_____
Child:	Y N	_____	_____
Child:	Y N	_____	_____
Partner(s):	Y N	_____	_____

Your Concerns

What do you hope to gain from therapy? How can I be most helpful?

Have you been in therapy in the past? If so, what worked? What didn't?

What have you tried doing to overcome your current challenges?

Is there anything else I should know before we start work together?