Confidential Client Registration

Date: _____

Last Name: _____ First: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone _____

Cell Phone: _____ Email Address _____
Circle the preferred contact method

Occupation: _____ Highest Level of Education _____

Birth Date: _____ Age: _____ Sex: Male _____ Female _____

Relational Status:

Single ____ Married ____ Widowed ____ Divorced ____ Separated ____ Engaged ____

If married: How long _____ Spouse's name: _____ Wedding Date _____

If previously married: How long _____ When ended? _____ How ended? _____

Children: Names	Ages	Ours, His, or Hers?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any Additional children can be listed on the back

Are you currently under medical care? _____ If yes, please indicate reason _____

_____

Do you (or spouse if marriage counseling) take any prescription medications? _____

If yes, what are they? _____

Other significant medical history _____

_____

Have you seen a mental health professional previously? _____

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If so, approximate start and ending dates: (start)_____ (end)_____

How was it helpful? _____

_____

Was any part of it not helpful? _____

_____

Why are you seeking counseling at this time? _____

_____

_____

_____

_____

How do you hope counseling will help? _____

_____

_____

_____

Spiritual history: Are you associated with any church or religious organization? _____

If so, which one _____ how long _____

On a scale from one (not very) to ten (extremely), how would you rate the importance of this association to your life? _____

On a scale from one (not at all) to ten (very important), how would you rate what part you want this area to play in your counseling? _____

Is there anything else you feel that is important for Mark to know? _____

_____

_____

_____