CLIENT REGISTRATION FORM

Name: _____

Address: _____

City: _____ Zip Code: _____

Phone(s): _____

E-mail: _____

DOB: _____ Preferred Pronouns _____

Employer: _____

Occupation: _____

Relationship Status: (check all that apply)

___ Single (never married) ___ Cohabitating ___ Married

___ Separated ___ Divorced ___ Widowed ___ Remarried

Spouse/Partner: _____ DOB _____

Address (if different): _____

Employer: _____ Occupation: _____

Children and/or other household members (names and ages). Please list any children, even if they're not living with you.

_____

_____

Have you ever seen a therapist before? ___ no ___ yes (please describe)

_____

_____

Referred by: _____

May I thank this person for the referral? ___ yes ___ no ___ n/a