Adult Registration

Date Completed:

Individuals come to counseling from many different walks of life and for many different reasons. Please help us assist you by filling out this form. This is a general form and some of the questions may not apply to you.

General Information:

Full Name:	Nickname:
Street Address:	City, State, Zip:
Date of Birth: Age:	Sex: ___ Male ___Female
Home Phone: ( )	Employer Name:
Employer Phone: ( )	Marital Status: __Single ___ Married ___Divorced ___ Widowed __ Cohabitating

Spouse:

Last Name:	First:	Middle Initial:

Marriage:

Date:	Place:

----------	Client	Spouse
Date of Birth:		
Place of Birth:		
Race/ Ethnicity		
Highest level of school completed:		
Number of Previous Marriages:		
Have you ever been arrested?	___Yes ___No	___Yes ___No
If “yes”, please explain:		

CHILDREN:

Name	Age	Sex	Relationship to you	Do they live in your home?

Others Living in the Home

Name	Age	Sex	Relationship to you

WORK HISTORY:(Starting with current position)

Client

Position	Employer	Dates of Employment

Spouse (starting with current position)

MEDICAL HISTORY:

Physician's Name: _____ Date of last medical exam_____

Rate your physical health:	Very Good _____	Good _____	Average ____	Declining _____	Poor ____
Rate your appetitie	Very Good _____	Good ____	Average ____	Declining _____	Poor ____

Weight Change:	Lost? How many pounds?	Gained? How many pounds?

List all important present or past illnesses, injuries, or handicaps

Illness/ Injury/ Disability	Dates	Results

List all prescription medication:

Name	Dosage	Reason	Physician

MENTAL HEALTH HISTORY:

List previous counseling experiences:

Therapist	**Dates**	**Reason**	**Results**

List any previous hospitalizations for mental health problems

Hospital	**Dates**	**Reason**	**Results**

List 5 words, either positive or negative that best describe you now:	1.	2.
3.	4.	5.

Have you ever felt people were watching you? (place an “x” by your answer	___ Yes	___ No
Have you ever seen or heard something that others did not?	___ Yes	___ No
Do colors seem too bright or too dull?	___ Yes	___ No
Are you afraid of anything in particular?	___Yes	___ No
Do people tell you that you have a bad temper?	___ Yes	___ No
Do people tell you that you drink (alcohol) too much?	___ Yes	___ No
Are you currently experiencing any of the following?		
Suicidal thoughts or feelings?	___ Yes	___ No
Homicidal thoughts or feelings?	___ Yes	___ No
Desire to cause pain to self or others?	___ Yes	___ No
Are you in fear of your life or personal safety?	___ Yes	___ No
Are you too depressed to care for self or family?	___ Yes	___ No

SPIRITUAL LIFE INFORMATION:

Do you have a spiritual practice or religion?	___ Yes	___ No
If yes, what is it?		
Do you believe in God?	___ Yes	___ No
If you identify as Christian (accepted Jesus Christ as savior), what is your denominational preference? (Baptist, Methodist, Church of God movement, etc.)		
Do you currently have a home church/ synagogue/ mosque, etc?	___ Yes	___No
If yes, where do you attend?		
Did you attend religious services as a child?	___ Yes	___ No
What is the religious background of your spouse?		
Have there been any recent changes in your spiritual life?	___ Yes	___ No
If “yes”, please elaborate:		