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New Client Registration

Name: ________________________________ Age: ________ Date Of Birth: _________

Address: ______________________ City: _______________ State: ______ Zip: ______

Home Phone: ______________ Cell Phone: ______________ Work Phone: ____________

Occupation: __________________________ Employer: __________________________

Marital Status: ___________ Spouse's Name ______________ Phone: _____________

(If student) School _______________ Grade/ Area Of Study _____________________

Referred By: ____________ Treating Physician: _____________ Phone: ____________

Emergency Contact: ________________ Relation: ___________ Phone: ____________

Address: ______________________ City: _______________ State: ______ Zip: ______

Insurance Co. Info: _______________________ Your E-mail _______________________

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All communication between the client and the therapist is private and confidential unless a release of information is authorized by the client.

Name: ____ Date: ___________________

Signature: ____

DSM: ____________________