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# REGISTRATION INFORMATION

*Please complete the following questions. We will discuss this information more thoroughly in our session and use it to determine goals for our work together.*

**Part One: Personal Background Information:**

Name: _____ Date of birth _____ Age ____

Address: _____ City _____ State____ Zip _____

Telephones (h) _____ (w) _____

Can I leave a message at home? ___ yes ___ no Can I leave a message at work? ___ yes ___ no

Can I reach you by email? ___ yes ___ no Email Address _____

When is the best time to reach you by email: _____

Emergency Contact (name): _____ Relationship: _____
Phone: _____

Did someone give you my name? ___ yes ___ no If yes, who? _____

May I thank them for the referral? ___ yes ___ no

What is your Occupation? _____ How long? _____

Employer:_____ Highest level of education: _____

How satisfied are you with your job? _____

Marital/Relationship Status (Check all that apply):

___ Married ___ Separated ___ Widowed ___Divorced ___ Remarried ___ Single

___ Long-term relationship ___ Cohabiting ___ Other

Current Partner's Name: _____ Length of Relationship: _____

How satisfied are you with this relationship? _____

Do you have any children (biological, adopted, step, foster)? ___ yes ___ no If yes, how many and what

are their ages? _____

Do your children currently live with you: ___ yes ___ no

If no, where do they live? _____

How often do you see them: _____

**Part Two: Counseling History/Reasons for Seeking Help**

Have you ever been in therapy before? ___ yes ___ no

If yes, briefly describe the reason(s), when, and for how long: _____

_____

If yes, was it a positive experience? ___ yes ___ no

What did you like/not like about it? _____

What was most helpful about it? _____

What was least helpful about it? _____

Have you ever attempted suicide? ___ yes ___ no If yes, when, and please describe briefly the situation:

_____

Have you ever seriously contemplated suicide (but never attempted): ___ yes ___ no

Are you currently having suicidal thoughts? ___ yes ___ no

Do you have any chronic illnesses, medical conditions, or injuries: ___ yes ___ no
If yes, please describe them: _____

_____

Are you presently taking any medication? ___ yes ___ no If yes, please list the medication and what it treats:

_____

Briefly describe your reason(s) for seeking help at this time:

_____

_____

_____

What do you wish to accomplish through the process of therapy?

_____

_____

_____

What do you enjoy doing in your spare time: _____

_____

Are there things that you used to do, or would like to do, but currently don't? _____

_____

How would you describe your spiritual or religious beliefs? _____

_____

Is there anything else you think would be important for me to know about you or your family?

_____

_____

_____

Please circle any of the following things that presently cause you difficulty:

| | | | |
|---|---|---|---|
| Assertiveness | Health problems | Career choices | Stomach problems |
| Parenting | Alcohol use | Self-concept | Guilt |
| Bowels | Sexual problems | Legal matters | Pre-menstrual |
| Menopause | Marriage | Religion | Nightmares |
| Loneliness | Concentration | Separation | Bedwetting |
| Ulcers | My thoughts | Suicidal thoughts | Nervousness |
| Energy | Sleep | Decision making | Children |
| Parents | Sexual abuse | Insomnia | Education |
| Divorce | Physical abuse | Relaxation | Ambition |
| Temper | Depression | Shyness | Stress |
| Inferiority | Friends | Dating | Memory |
| Drug use | Headaches | Tiredness | Finances |
| Appetite | School | Work | Confusion |
| Premarital | Food | Self-control | Weight |
| Sadness | Anxiety | In-laws | My past |
| Fears | Anger | Unhappiness | |

Other _____ _____

*Now place an "*" by the items that are causing you the MOST difficulty.*