Client Registration

HOPE RENEWED

PERSONAL INFORMATION

Name (First, Middle Initial, Last)			**Date**
Mailing Address	**City**	**State**	**Zip Code**

Home Phone	**Work Phone**	**Cell Phone**
( )	( )	( )

Where may I contact you? (Check all that apply.)
▫ Home Phone ▫ Work Phone ▫ Cell Phone
▫ Address ▫ Other Address

Where may I leave a message? (Check all that apply.)
▫ Home Phone ▫ Work Phone ▫ Cell Phone
▫ Other: _____

Age	**Date of Birth** (MM/DD/YYYY)	**Marital Status**	**Gender**
		▫ Single ▫ Divorced ▫ Separated ▫ Married ▫ Widowed	▫ Male ▫ Female

Race
▫ Caucasian/White ▫ Native American ▫ Native Hawaiian/Pacific Islander ▫ Multiple Race
▫ Black/African American ▫ Asian ▫ Alaskan Native ▫ Unknown

Ethnicity
▫ Puerto Rican ▫ Mexican ▫ Cuban ▫ Other Hispanic ▫ Not Hispanic/Latino

SPOUSE/PARTNER INFORMATION

Spouse/Partner Name (First/Last) ▫ No Spouse/Partner			**Contact Phone**
Age	**Date of Birth** (MM/DD/YYYY)	**Quality of Relationship**	**Involved in Therapy?** ▫ Yes ▫ No

EMERGENCY CONTACT INFORMATION

Emergency Contact Person	**Contact Phone** ( )
Relationship to Client	**May we leave a message?** ▫ Yes ▫ No

EMPLOYMENT INFORMATION

Current Employer ▫ No Employer/Unemployed ▫ Student		**Hours/Week**
Occupation	**Length of Employment** Months _____ Years _____	**Phone** ( )
Spouse/Partner Employer ▫ No Employer/Unemployed ▫ Student		**Hours/Week**
Spouse/Partner Occupation	**Length of Employment** Months _____ Years _____	**Phone** ( )

MEDICAL HISTORY INFORMATION

Physical Health

▫ Excellent ▫ Good ▫ Fair ▫ Poor

Height

Weight

Past Attempts to Harm Self or Others

▫ None ▫ Self ▫ Others ▫ Property

Comments: ▫ No Comments

Current Risk of Harm to SELF

▫ None

Comments: ▫ No Comments

Current Risk of Harm to OTHERS

▫ None

Comments: ▫ No Comments

Serious Illnesses, Accidents, and Operations (Describe issue, side effects, etc.)

Current Behaviors and Symptoms (Select all that apply.)

▫ Aggression	▫ Dizziness	▫ Irritability	▫ Sick Often
▫ Alcohol Dependence	▫ Drug Dependence	▫ Judgment Errors	▫ Sleeping Problems
▫ Anger	▫ Eating Disorder	▫ Loneliness	▫ Substance Use/Abuse
▫ Antisocial Behavior	▫ Elevated Mood	▫ Memory Impairment	▫ Suicidal Thoughts
▫ Anxiety	▫ Fatigue	▫ Mood Shifts	▫ Thoughts Disorganized
▫ Avoiding People	▫ Gambling	▫ Panic Attacks	▫ Trembling
▫ Chest Pain	▫ Hallucinations	▫ Phobias/Fears	▫ Withdrawal
▫ Cyber-Addiction	▫ Heart Palpitations	▫ Pornography Addiction	▫ Worrying
▫ Depression	▫ High Blood Pressure	▫ Recurring Thoughts	▫ Worthlessness
▫ Disorientation	▫ Hopelessness	▫ Sexual Addiction	▫ Other:
▫ Distractibility	▫ Impulsivity	▫ Sexual Difficulties	_____

Have you ever been to counseling before?

▫ Yes ▫ No

Did you find it helpful?

▫ Not at All ▫ A Little ▫ Moderate ▫ Much

Did you receive a previous diagnosis?

Are you currently taking any medications? If so, please indicate what you are taking and what it is prescribed for.

PRESENTING ISSUES

What brings you to counseling now? How would you describe your current issue(s)?

What would you like to see achieved through counseling?

RELIGIOUS/SPIRITUALITY INFORMATION

Religious History

Affiliated with a Group? ▫ Yes ▫ No

Importance of Spiritual Matters

▫ Not at All ▫ A Little ▫ Moderate ▫ Much

Religious Affiliation/Denomination

Length of Attendance

Months _____ Years _____

Member/Partner

▫ Yes

▫ No

Congregation Name ▫ No Congregation

City

State

Do you want your faith incorporated into your counseling?

▫ Not at All

Any additional comments about this?

How important is your faith/religion to you and your daily life?

▫ No Religious Practices