Genesis Counseling, LLC
Client Information & Registration Form

Client Information

Name: ____ ____________________
First Middle Initial Last Preferred Name

SS#: ________________ DOB: ____________ Age: _______ Gender: _____ Marital Status: ____________

Address: ____

City/State/Zip: ____

Home Ph: ________________________________ May we leave a message? Yes No

Work Ph: ________________________________ May we leave a message? Yes No

Cell Ph: ________________________________ May we leave a message? Yes No

E-mail: ____

If the above client is an Adult:

Employer: ________________________________ Occupation: ________________________

Spouse: ____

Employer: ________________________________ Occupation: ________________________

SS#: ________________ DOB: ____________ Age: _______ Gender: _____ Marital Status: ____________

Work Ph: ________________________________ May we leave a message? Yes No

Cell Ph: ____________________________ May we leave a message? Yes No

If the above client is a Minor:

Parent/Guardian 1: ____________________________ Relationship to client: ______________

Address: ____

City/State/Zip: ____

Employer: ________________________________ Occupation: ________________________

SS#: ________________ DOB: ____________ Age: _______ Gender: _____ Marital Status: ____________

Home Ph: ________________________________ May we leave a message? Yes No

Work Ph: ________________________________ May we leave a message? Yes No

Cell Ph: ________________________________ May we leave a message? Yes No

E-mail: ____

Parent/Guardian 2: ____________________________ Relationship to client: ______________

Address: ____

City/State/Zip: ____

Employer: ________________________________ Occupation: ________________________

SS#: ________________ DOB: ____________ Age: _______ Gender: _____ Marital Status: ____________

Home Ph: ________________________________ May we leave a message? Yes No

Work Ph: ________________________________ May we leave a message? Yes No

Cell Ph: ________________________________ May we leave a message? Yes No

E-mail: ____

Referral/Emergency Contact

How did you hear about us? ____

Referred by: ____

Emergency Contact: ____________________________ Phone: __________________________

Household Information

Individuals Living in Your Home:

Name	Age	Relationship

Client History

What are you seeking help for? ____

____

Are you currently seeing, or have you in the past seen another professional for this? Current Past No

If Yes, please specify: ____

____

Substance Use History (drugs, alcohol, tobacco, etc.): ______________________________

Current Medical Physician: ____

Please list any Current, or Important Past, Medications:

Medication & Dose	Date	Response

Have you ever been admitted to a psychiatric hospital? Yes No

If Yes, please explain: ____

____

____

Are you currently experiencing thoughts of harming either yourself or someone else? Yes No

Have you in the past experienced thoughts of harming either yourself or someone else? Yes No

Do you currently have any pending criminal charges? Yes No If yes, explain: ______________

____

Have you ever been convicted of a crime? Yes No If yes, explain: ______________

____

Does your family currently have Division of Family Services involvement? Yes No

If yes, please provide the DFS Case Worker's Name: ______________________ Ph: ______________

Is there anything else you would like us to know? ____

____

____

Signature: ____ **Date:** ______________