

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:** _____