Brightside Counseling Services, LLC

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Adult Registration Form

Today's date:	Therapist:

Referral source: ❑ Psychology Today ❑ Good Therapy ❑ Google Search Term_____
❑ Person (who)_____ ❑ Other _____

Primary reason for coming in:

CLIENT INFORMATION

Last name:	First name:	Middle name:	Date of birth:	Age:	Social Security Number

Address:	PO Box/Apt. no:	City:	State:	Zip code:

Occupation:	Employer:	Length at job:	Email address:

Work phone no.:

Cell phone no.:

Home phone no.:

Racial/ Ethnic Origin:
❑Latino/a ❑African ❑Caucasian
❑African American ❑Middle Eastern
❑Asian/Pacific Islander ❑Alaska Native
❑Native American/Indian
❑Multicultural_____
❑ Other_____
❑ I would not like to disclose

Preferred way to be contacted:
❑ Cell ❑Home ❑Work ❑ Mail ❑ Email

Can I leave a message?: ❑Yes ❑No
Can I send you a text?: ❑Yes ❑No

Spiritual/Religious Affiliation:
❑Catholic ❑Protestant ❑Muslim ❑Hindu
❑Buddhist ❑Jewish ❑Atheist ❑ Islam
❑Mormon ❑Baptist ❑Episcopal ❑Lutheran
❑Methodist ❑Presbyterian
❑Chinese Traditional ❑ Non-Denominational
❑Other: _____
❑ I would not like to disclose

Are you currently practicing your religion?

❑Yes ❑No ❑I would not like to disclose

Relationship status:
❑Single ❑Married
❑ Divorced ❑Widowed
❑ Separated
❑ Cohabitating partner
❑Non-cohabitating partner
❑Other_____

Name of partner/wife/husband:

Sexual orientation:
❑Straight/Heterosexual
❑Gay/Homosexual
❑Bi/Bisexual
❑Transgender M to F F to M
❑Not sure
❑Other_____
❑ I would not like to disclose

Primary care physician:	Primary care physician phone no.:	Last visit:	Length of time with PCP:

Have you been in therapy before? If yes, with who?:	Do you have a psychiatrist? If yes, who?	Psychiatrist's phone no.:

List any medications you are taking (OTC or Prescribed) and what it's treating:

Medication:	Treating:
1.	
2.	
3.	
4.	
5.	
6.	

List family (parents, children, siblings):

Relative:	Age:	Living with you?:
1.		
2.		
3.		
4.		
5.		
6.		

IN CASE OF EMERGENCY

Name of a friend or relative:	Relationship:	Phone no.: