

### Child/Adolescent Registration Form

Today's Date:			Therapist:			
Referral Source: <input type="checkbox"/> Psychology Today <input type="checkbox"/> Good Therapy <input type="checkbox"/> Google Search Term _____						
<input type="checkbox"/> Person (who) _____ <input type="checkbox"/> Other _____						
Primary Reason for coming in:						
<b>CLIENT INFORMATION</b>						
Child's Legal Last name:		First name:	Middle name:	Date of birth:	Age:	Social Security Number
Address:		PO Box/Apt. no:	City:		State:	Zip code:
Child's home phone no.:		Child's cell phone no.:		Child's email address:		
Racial/ Ethnic Origin: <input type="checkbox"/> Latino/a <input type="checkbox"/> African <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Alaska Native <input type="checkbox"/> Native American/Indian <input type="checkbox"/> Multicultural _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> I would not like to disclose		Spiritual/Religious Affiliation: <input type="checkbox"/> Catholic <input type="checkbox"/> Protestant <input type="checkbox"/> Muslim <input type="checkbox"/> Hindu <input type="checkbox"/> Buddhist <input type="checkbox"/> Jewish <input type="checkbox"/> Atheist <input type="checkbox"/> Islam <input type="checkbox"/> Mormon <input type="checkbox"/> Baptist <input type="checkbox"/> Episcopal <input type="checkbox"/> Lutheran <input type="checkbox"/> Methodist <input type="checkbox"/> Presbyterian <input type="checkbox"/> Chinese Traditional <input type="checkbox"/> Non-Denominational <input type="checkbox"/> Other: _____ <input type="checkbox"/> I would not like to disclose  Are you currently practicing your religion?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I would not like to disclose		Sexual orientation: <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Gay/Homosexual <input type="checkbox"/> Bi/Bisexual <input type="checkbox"/> Transgender M to F F to M <input type="checkbox"/> Not sure <input type="checkbox"/> Other _____ <input type="checkbox"/> I would not like to disclose		
Current Living Situation: <input type="checkbox"/> Both parents together <input type="checkbox"/> Both parents separately <input type="checkbox"/> Single parent with visitation <input type="checkbox"/> Single parent with no visitation <input type="checkbox"/> Blended family <input type="checkbox"/> Foster or Adoptive family <input type="checkbox"/> Group home <input type="checkbox"/> Emancipated <input type="checkbox"/> Other _____ <input type="checkbox"/> Relevant info. Regarding this: _____			Have you experienced any of the following? Check all that apply: <input type="checkbox"/> Developmental delay/disability <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Learning difficulties <input type="checkbox"/> Behavioral problems <input type="checkbox"/> Legal problems <input type="checkbox"/> History of physical abuse <input type="checkbox"/> Low self esteem <input type="checkbox"/> Depression <input type="checkbox"/> History of sexual abuse <input type="checkbox"/> Suicidal <input type="checkbox"/> Substance use/abuse <input type="checkbox"/> Self harm <input type="checkbox"/> Hospitalization for mental health <input type="checkbox"/> Death <input type="checkbox"/> Health problems <input type="checkbox"/> Fears <input type="checkbox"/> Anger <input type="checkbox"/> Relationship problems <input type="checkbox"/> Social problems <input type="checkbox"/> Sadness <input type="checkbox"/> Nightmares <input type="checkbox"/> Family problems <input type="checkbox"/> Divorce <input type="checkbox"/> Autism/Asperger's <input type="checkbox"/> Other _____ <input type="checkbox"/> Relevant info. Regarding this: _____			
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:			List family (parents, children, siblings):			
Medication/dose:		Treating:	Relative:	Age:	Living with you?:	
1.			1.			
2.			2.			
3.			3.			
4.			4.			
5.			5.			

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LEGAL GUARDIAN 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.:		Preferred way to be contacted: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mail <input type="checkbox"/> Email				Relationship status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Cohabiting partner <input type="checkbox"/> Non-cohabiting partner <input type="checkbox"/> Other _____	
Cell phone no.:		Can I leave a message?: Can I send you a text?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No				Name of partner/wife/husband:	
Home phone no.:		Spiritual/Religious Affiliation: <input type="checkbox"/> Catholic <input type="checkbox"/> Protestant <input type="checkbox"/> Muslim <input type="checkbox"/> Hindu <input type="checkbox"/> Buddhist <input type="checkbox"/> Jewish <input type="checkbox"/> Atheist <input type="checkbox"/> Islam <input type="checkbox"/> Mormon <input type="checkbox"/> Baptist <input type="checkbox"/> Episcopal <input type="checkbox"/> Lutheran <input type="checkbox"/> Methodist <input type="checkbox"/> Presbyterian <input type="checkbox"/> Chinese Traditional <input type="checkbox"/> Non-Denominational <input type="checkbox"/> Other: _____ <input type="checkbox"/> I would not like to disclose					
Racial/ Ethnic Origin: <input type="checkbox"/> Latino/a <input type="checkbox"/> African <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Alaska Native <input type="checkbox"/> Native American/Indian <input type="checkbox"/> Multicultural _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> I would not like to disclose		Are you currently practicing your religion? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I would not like to disclose				Sexual orientation: <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Gay/Homosexual <input type="checkbox"/> Bi/Bisexual <input type="checkbox"/> Transgender M to F F to M <input type="checkbox"/> Not sure <input type="checkbox"/> Other _____ <input type="checkbox"/> I would not like to disclose	
Relationship to client: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Relative: _____ <input type="checkbox"/> Other: _____			Any other detail that you would like to share?:				
ADDITIONAL GUARDIAN 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.:		Preferred way to be contacted: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mail <input type="checkbox"/> Email				Sexual orientation: <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Gay/Homosexual <input type="checkbox"/> Bi/Bisexual <input type="checkbox"/> Transgender M to F F to M <input type="checkbox"/> Not sure <input type="checkbox"/> Other _____ <input type="checkbox"/> I would not like to disclose	
Cell phone no.:		Can I leave a message?: Can I send you a text?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No					
Home phone no.:							

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<p><b>Racial/ Ethnic Origin:</b>  <input type="checkbox"/> Latino/a   <input type="checkbox"/> African   <input type="checkbox"/> Caucasian  <input type="checkbox"/> African American   <input type="checkbox"/> Middle Eastern  <input type="checkbox"/> Asian/Pacific Islander   <input type="checkbox"/> Alaska Native  <input type="checkbox"/> Native American/Indian  <input type="checkbox"/> Multicultural _____  <input type="checkbox"/> Other _____  <input type="checkbox"/> I would not like to disclose</p>	<p><b>Spiritual/Religious Affiliation:</b>  <input type="checkbox"/> Catholic   <input type="checkbox"/> Protestant   <input type="checkbox"/> Muslim   <input type="checkbox"/> Hindu  <input type="checkbox"/> Buddhist   <input type="checkbox"/> Jewish   <input type="checkbox"/> Atheist   <input type="checkbox"/> Islam  <input type="checkbox"/> Mormon   <input type="checkbox"/> Baptist   <input type="checkbox"/> Episcopal   <input type="checkbox"/> Lutheran  <input type="checkbox"/> Methodist   <input type="checkbox"/> Presbyterian  <input type="checkbox"/> Chinese Traditional   <input type="checkbox"/> Non-Denominational  <input type="checkbox"/> Other: _____  <input type="checkbox"/> I would not like to disclose</p> <p>Are you currently practicing your religion?</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> I would not like to disclose</p>	<p><b>Relationship status:</b>  <input type="checkbox"/> Single   <input type="checkbox"/> Married  <input type="checkbox"/> Divorced   <input type="checkbox"/> Widowed  <input type="checkbox"/> Separated  <input type="checkbox"/> Cohabiting partner  <input type="checkbox"/> Non-cohabiting partner  <input type="checkbox"/> Other _____          Name of partner/wife/husband:</p>
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**IN CASE OF EMERGENCY**

Name a local friend or relative (please have one not living with you):	Relationship:	Phone no.:
1.		
2.		