NEW CLIENT REGISTRATION

Dykstra Counseling, LLC
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Demographic Information

Today's Date: _____

Name of Client: _____ Age: _____ Gender(s): _____

Mailing Address: _____

Email Address: _____

Date of Birth: _____

Home Phone: _____May I Call This Number? Y N Leave a Message? Y N

Cell Phone: _____ May I Call This Number? Y N Leave a Message? Y N

Person Responsible for Bill: _____

Relationship: _____

Address: _____

Phone: _____

Email: _____

CLIENT EMPLOYER INFORMATION

Employer: _____

Occupation: _____

Address:_____

Work Phone: _____ May I Call This Number? Y N Leave a Message? Y N

INSURANCE INFORMATION

Name of Insured: _____ Date of Birth: _____

Primary Insurance Company: _____

Address: _____ Phone: _____

Subscriber/ID #: _____ Group #: _____

Secondary Insurance Company:

Name of Insured: _____

Social Security#:_____ DOB: _____

Address: _____

Phone: _____

Subscriber/ID #: _____ Group #: _____

PHYSICIAN & REFERRAL INFORMATION

Name of Physician: _____ Phone:_____

Name of Therapist/Counselor: _____ Phone: _____

Who referred you to our office? _____ Relationship: _____

MEMBERS OF THE HOUSEHOLD

Name	Relationship to Client	Age	Gender Identity

CLIENT SCHOOL INFORMATION ☐ **N/A**

Name of School: _____

Current Grade Level: _____ Average Grade Point: _____

PERSONAL INFORMATION

Sexual Orientation(s):_____

Religious/Spiritual Identities: _____

Ethnic and Racial Identities:

_____

Please describe any other parts of your cultural identities you feel are important for your therapist to know:

_____

_____

Please describe your average monthly frequency and amount used of the following substances:

Alcohol:_____

Caffeine:_____

Tobacco:_____

Prescription drugs for which you do not have a prescription:
_____

Marijuana:_____

Other non-prescription
drugs:_____

MEDICAL HISTORY

Please list any current medications you are prescribed:
_____
_____
_____
_____

Please name any chronic conditions you have been diagnosed with:
_____
_____
_____
_____

Please record any major hospitalizations for either medical or psychiatric reasons:
_____
_____

Have you participated in psychotherapy in the past? If so, what were your reasons for attending?
_____
_____
_____

Generally, how do you feel about beginning psychotherapy now?
_____
_____
_____
_____

EMERGENCY CONTACT

If Emergency, Contact: _____

Relationship: _____

Address: _____

Home Phone: _____Work Phone: _____

Legal Next of Kin: _____ Relationship: _____

Address: _____

Home Phone: _____Work Phone: _____

I HAVE READ THE OFFICE POLICY AND ACCEPT ITS CONTENTS

_____ _____

Signature Date

_____ _____

Additional Client or Parent Signature Date