ART OF THE HEART
COUNSELING SERVICES LLC

**NEW CLIENT REGISTRATION (Adult)**

Date: _____ How did you find our practice? _____

## CLIENT INFORMATION

Client's Full Name: _____ Preferred Name: _____

Full Address: _____

Date of Birth: _____ Client's Sex: _____ Gender/Pronouns: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Permission to Contact:

[ ] Email OK [ ] Text/Voicemail OK [ ] Text Only OK [ ] Voicemail Only OK

Employer: _____ Occupation: _____

Race and Ethnicity: _____

## OTHER RELEVANT CONTACT INFORMATION: (spouse/partner/family member/etc.)

Contact Name: _____

Address: _____

Date of Birth: _____Relationship to Client: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Permission to Contact:

[ ] Email OK [ ] Text/Voicemail OK [ ] Text Only OK [ ] Voicemail Only OK

[ ] Do not contact

**EMERGENCY CONTACT:**

Name: _____ Phone: _____Relationship: _____

**FINANCIALLY RESPONSIBLE PARTY:**

[ ] Self

[ ] Other Person:

Name: _____ Phone: _____Relationship: _____

**WHO ELSE LIVES IN YOUR CURRENT PRIMARY RESIDENCE? (Name, Age, Relationship to Client)**

| Name | Age | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**INSURANCE INFORMATION: (Please provide a copy of the front and back of your insurance card.)**

**Primary Insurance:**

Insurance Plan: _____ Insurance Phone Number _____

ID# _____ Group# _____ Employer: _____

Name of Primary Insured: _____ Date of Birth: _____

**Secondary Insurance:**

Insurance Plan: _____ Insurance Phone Number _____

ID# _____ Group# _____ Employer: _____

Name of Primary Insured: _____ Date of Birth: _____

**CLIENT'S MEDICAL AND PSYCHOTHERAPY HISTORY:**

Previous psychotherapy history: _____

Pediatrician: _____ Phone: _____

Psychiatrist (if any): _____ Phone: _____

Other Providers (e.g., occupational therapist, speech therapist, psychologist, etc.):

Provider Name: _____ Phone: _____

Provider Name: _____ Phone: _____

Health Issues or Allergies: _____

Medications: _____

**THERAPY GOALS:**

Please give a brief description of your primary concern.

_____

_____

What do you hope to achieve or gain with therapy?

_____

_____

I am acknowledging that the information I provided here is true to the best of my knowledge.

Printed Name: _____

Signature: _____ Date: _____