COLORADO IN-HOME COUNSELING

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Client Registration Form

Today's Date: _____

Client Information:

Name: _____ Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

How may I contact you?

(Check and fill in all that apply)

☐ Home Phone: _____ Voicemail OK? ☐ Yes ☐ No

☐ Cell Phone: _____ Voicemail OK? ☐ Yes ☐ No | Text OK? ☐ Yes ☐ No

☐ Work Phone: _____ Voicemail OK? ☐ Yes ☐ No

☐ Email: _____

Are you interested in receiving appointment reminders?

(If yes, check your preferences)

☐ Text Message or ☐ Voicemail:_____

☐ Email: _____

Relationship Status:

(Check all that apply)

☐ Single (never married) ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

☐ Common Law ☐ Non-cohabitating partner ☐ Cohabitating partner

Name of Partner/Spouse: _____

Children:

Please list names/ages of your children, step-children, foster children below:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Emergency Contact Information:

Name: _____ Relationship to client: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Cell phone: _____

Referral Information:

How did you hear of Colorado In-Home Counseling? (e.g. current/former client, therapist, physician, friends/family, Google search, Psychology Today, etc?)

_____

If a person directly referred you to Colorado In-Home Counseling, please let me know whom to thank!

May I contact this person to thank them? ☐ Yes ☐ No