Nathaniel D. Smith,
Licensed Professional Counselor

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NEW CLIENT REGISTRATION FORM (PLEASE PRINT)

CLIENT INFORMATION					
Last Name:	First Name:	MI	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital status:	
Drivers License #:	Social Security #:	Birth date:	Age:	Gender: ☐ M ☐ F	
Street Address:	City:	State:	Zip:		
Home Phone #:	Work Phone #:	Mobile/Pager Phone #:	Email Address:		
Occupation:	Employer:	Employer Phone #:			
Spouse/Partner's Last Name:	First Name:	MI	Social Security #:		
Home Phone #:	Work Phone #:	Mobile/Pager Phone #:	Email Address:		
Please list any other persons living in your household:	How were you referred to this service?				
Emergency Contact:	Relationship:	Phone #:			

INSURANCE INFORMATION			
Primary Insurance Company:	Insurance Company Phone #:		
Insurance Company Street Address:	City:	State:	Zip:
Name of Subscriber:	Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other:		
Subscriber's Social Security #:	Group ID #:	Subscriber #:	Policy #:
Name of Secondary Insurance (if applicable):	Insurance Company Phone #:		
Insurance Company Street Address:	City:	State:	Zip:
Name of Subscriber:	Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other:		

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to this counselor. I understand that I am financially responsible for any balance. I authorize this counselor or insurance company to release any information required to process my claims.

Client/Guardian Signature: _____ *Date:* _____

NEW CLIENT REGISTRATION FORM, continued

MENTAL HEALTH QUESTIONAIRRE

Please describe your reason(s) for seeking counseling at this time. Include date/month/year problem started:

Was there an event that made these issues or problems surface? ☐ Yes ☐ No If yes, please describe:

What results do you expect from counseling?

Please rate the severity (1-4) of the following issues/problems you would like to work on in counseling: None (1) Mild (2) Moderate (3) Severe (4)

_____ Depression	_____ Lack of friends	_____ Marriage/Relationships
_____ Anxiety	_____ Loneliness	_____ Sexuality/Sexual Issues
_____ Anger	_____ Coping Problems	_____ Family Conflict
_____ Controlling Stress	_____ Abuse/Victimization	_____ Behavioral Problems
_____ Loss of loved one	_____ Financial Problems	_____ Legal Problems
_____ Problems at school/work	_____ Drug/Alcohol Problems	_____ Religious Issues
_____ Intrusive or repetitive thoughts	_____ Other (example: gambling, etc.):	_____

Please indicate how the issues for which you are seeking counseling are effecting the following area of your life:

	No Effect	Little Effect	Some Effect	Much Effect	Not Applicable
Marriage/Relationship	☐ 1	☐ 2	☐ 3	☐ 4	☐ N/A
Family	☐ 1	☐ 2	☐ 3	☐ 4	☐ N/A
Job/School Performance	☐ 1	☐ 2	☐ 3	☐ 4	☐ N/A
Friendships	☐ 1	☐ 2	☐ 3	☐ 4	☐ N/A
Financial Situation	☐ 1	☐ 2	☐ 3	☐ 4	☐ N/A
Physical Health	☐ 1	☐ 2	☐ 3	☐ 4	☐ N/A
Anxiety Level/Nerves	☐ 1	☐ 2	☐ 3	☐ 4	☐ N/A
Mood (Sadness, Depression)	☐ 1	☐ 2	☐ 3	☐ 4	☐ N/A
Eating Habits	☐ 1	☐ 2	☐ 3	☐ 4	☐ N/A
Sleeping Habits	☐ 1	☐ 2	☐ 3	☐ 4	☐ N/A
Sexual Functioning	☐ 1	☐ 2	☐ 3	☐ 4	☐ N/A
Ability to Concentrate	☐ 1	☐ 2	☐ 3	☐ 4	☐ N/A
Spirituality/Faith	☐ 1	☐ 2	☐ 3	☐ 4	☐ N/A
Ability to Control Temper	☐ 1	☐ 2	☐ 3	☐ 4	☐ N/A

NEW CLIENT REGISTRATION FORM, continued

PHYSICAL HEALTH QUESTIONAIRRE

Do you have any known allergies to food/medications, etc.? ☐ Yes ☐ No If yes, please explain:

Please list any prescription medications you currently use *(Include name, dosage, frequency):*

Please list any over the counter medications you currently use *(Include name, dosage, frequency):*

Please list any hospitalizations from past illness *(Include name of hospital, dates of confinement, the type of illness, and any procedures):*

Are you currently being treated for any medical conditions? ☐ Yes ☐ No If yes, please list:

When was your last physical examination done?	Was their any significant findings?

Do you experience any of the following? *(Please check all the apply)*

- ☐ Double or poor vision
- ☐ Difficulty hearing
- ☐ Fainting
- ☐ Blackouts
- ☐ Convulsions
- ☐ Dizziness
- ☐ Headaches
- ☐ Thyroid problems
- ☐ Cough or wheezing
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Palpitation or heart fluttering
- ☐ Swelling of hands or feet
- ☐ Unusual excessive thirst/dry mouth
- ☐ Indigestion, gas, heartburn
- ☐ Stomach pain
- ☐ Diarrhea or constipation
- ☐ Blood in stool
- ☐ Change in appetite or eating habits
- ☐ Trouble sleeping
- ☐ Sexual problems
- ☐ Problems with thinking, concentration, memory
- ☐ Weakness or tiredness
- ☐ Joint pain
- ☐ Lumps in body (please explain)
- ☐ Weight ☐ gain or ☐ loss
  # lbs: _____ Time Period: _____

Have you ever sought or received counseling before? ☐ Yes ☐ No If yes, please list:

Type of Treatment	Provider Name	Dates Seen	Diagnosis	Medication	(If applicable)
					☐ inpatient ☐ outpatient
					☐ inpatient ☐ outpatient
					☐ inpatient ☐ outpatient
					☐ inpatient ☐ outpatient

Have you ever abused Drugs or Alcohol? ☐ Yes ☐ No If yes, please explain *(Include substance, amount, frequency, last taken):*

Has anyone in your family had a serious illness? ☐ Yes ☐ No If yes, please describe:

Has anyone in your family had a psychiatric (nervous or mental) illness? ☐ Yes ☐ No If yes, please describe:

Has anyone in your family had a substance abuse problem? ☐ Yes ☐ No If yes, please describe:

Thank you for providing me with an account of your health and well being. This information will help me design a treatment plan geared specifically to your individual needs. I have always believed in fitting the treatment to the client- not the client to the treatment. Please feel free to discuss at any time any aspect of your answers or your treatment plan.