Date:_________________________

Sarah McKnight, LMFT

New Client Registration

YOUR NAME:____ Social Security Number: ___________-__________-____________

Date of birth: _______/________/___________ Relationship status: ___________________Height: ____'_____" Weight____________

Address:____ City:________________________ Zip:__________________

Home Phone: (__________)__________________________________ Work: (__________)_________________________________

Cell Phone: (__________)____________________________________ Other: (__________)________________________________

E-mail (print neatly!):____ Alternate e-mail:_____________________________

Occupation:________________________________ If employed, employer name:____

If in relationship, how long? ______________ Previously married? ________If so, how often, and how long?_____________________

SPOUSE OR SIGNIFICANT OTHER ***(complete even if s/he is not participating in therapy)***

Name:____ Social Security Number: ___________-__________-____________

Date of birth: _______/________/___________ Relationship status: __________________Height: ____'_____" Weight____________

Address (if not living with you):____ City:______________________ Zip:__________

Home Phone: (__________)__________________________________ Work: (__________)_________________________________

Cell Phone: (__________)_____________________________________ Other: (__________)_________________________________

E-mail:____ Alternate e-mail:____

Occupation:______________________________ If employed, employer name:____

Previously married?________ If so, how often, and how long?____

Who else lives in your home? Name_____________________________________ Age:_______ Relationship:____________________

Name_____________________________________ Age:_______ Relationship:____________________

Name_____________________________________ Age:_______ Relationship:____________________

Name_____________________________________ Age:_______ Relationship:____________________

Any children who live outside the home? (give names and ages)____

Insurance Plan:_________________________________ **Full Name of primary insured**:_______________________________________

If primary insured is not you, give their date of birth: _____/______/_______ **and their employer**:______________________________

Emergency Contact (not partner): ____________________________ Phone:(______)________________ Relationship:______________

Primary Doctor::____ Phone: (_______)______________________________

Doctor's address:____ City:____

Psychiatrist (if any): ____ Phone: (_______)_____________________________

Psychiatrist's address:____ City:____

Health Issues/Allergies: ____

____

Medications and Over-the-Counter Drugs taken regularly (include dosages and why you take them):______________________________

____

Alcohol: Average number of drinks per week___________________ Average number of drinks when you drink:______________________

Marijuana / other non-prescription drugs (drug you use, how much use, how often): ____

Has anyone ever been concerned about your alcohol or drug use?___________ If so, who?______________________________________

Cigarettes: Average use per day:___________________________________ Desire to quit?____

Who referred you to my practice? _____________________________________ **Did you look at my website before coming?**_________

Word or sentence to describe your life or how you feel:____