Glow Counseling Registration Form

Today's Date_____/_____/201__

Name: _____
(client's name)

DOB: _____/_____/_____ Age: _____

Name I prefer to be called (if different from above):_____

Address: _____ _____ _____
(Street) (City/zip code) (County)

Phone: (____)_____ (____)_____ (____)_____
(Home) (Cell) (Work)

SSN#: _____ Education Level:_____ E-mail:_____

Ethnic Origin: ____ African ____African-American ___Asian ___Caucasian___Latino/a ___Middle Eastern ___Native American/Indian ___Alaskan Native ___Multicultural: _____ other: _____

Religious/Faith affiliation: _____ Religion raised with:_____

Sexual orientation/identity: ____ Bisexual ____Gay ___Heterosexual/Straight ___Lesbian ___Queer ___Questioning ___Transgender ___Other:_____

Relationship Status: ___married ____common law ____single ___separated___ divorced ___non-cohabiting partner ___cohabiting partner ___widowed ___ other:_____

Name of Partner? Wife/Husband: _____ Time together:_____

List your children, stepchildren, and foster children below:

Name	Age	Birth Date	Relationship	Living with you?
				Yes No
				Yes No
				Yes No
				Yes No

**For clients under 18 years old, please fill out information below.*

Parent/Guardian(s) Name(s): _____

Type of Custody ____N/A ____joint ____sole ____residential ____no custody

Custody Information:

_____	_____
(Name)	(Name)
_____	_____
(Address)	(Address)
_____	_____
(Phone)	(Phone)

List your siblings in rank order of their birth. Next to their name, indicate their age:_____
_____
_____What is your birth order? _____

Who are the adults you grew up with? (Please list below)

Name	Relationship	Living?

Clients Occupation:_____ Employer:_____

Address: _____ _____
(Street) (City, State, Zip)

Length of Employment in Present Position: _____

Primary Care Physician: _____

Present Health Concerns: _____

Will you be using Medical Insurance?: Yes No *If yes, please indicate provider:_____

Medications: Yes No *If yes, please list meds and give reason: _____

Hospitalizations: Yes No *If yes, please list dates and give reason: _____

Previous Counseling: Yes No *If yes, please list dates and give reason:_____

Who to call in case of emergency?:_____

Name(s) & phone number(s) People in your support system:_____

How do you hear about us? ____ referral ____website ____internet search ____flyer/mailer ____phone book ____lecture/workshop ____advertisement ____Other:_____Referral source: _____

____ Check here if you would like to receive a confidential monthly mental health related newsletter via e-mail (you may unsubscribe at any time). email:_____