Date:________________________ **Khaila Haddadin, MFT**

New Client Registration

CLIENT:

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

Date of birth: _______/________/__________ Relationship status:_________________

Address:____ City:______________________ Zip:_________________

Home Phone: (__________)______________________________ Work: (__________)________________________________

Cell Phone: (__________)________________________________ May we leave a message? □ Yes □ No

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

Occupation:______________________________ If employed, employer name:_____________________________________

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced

If in relationship, how long? _________________________

Referred by (if any): _______________________________

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

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

Date of birth: _______/________/__________ Relationship status:_________________

Address:____ 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:___________________

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes,

previous therapist/practitioner: _____________________________________

Insurance Plan:_____________________________________ Name of primary insured (employee):__________________________

Emergency Contact : ___________________________ Phone:(______)_______________ Relationship:_______________________

Primary Doctor::____ Phone: (_______)_____________________________

Doctor's address:____ City:____________________________________

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

Psychiatrist's address:____ City:____________________________________

Health Issues/Allergies: ____

____

Are you currently taking any prescription medication? □ Yes □ No

Please list: ____

____

Have you ever been prescribed psychiatric medication? □ Yes □ No

Please list and provide dates (include dosages and why you take them):

____-

----______________________________

____-

----______________________________

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

____

How would you rate your current sleeping habits? (please circle) Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

____

How many times per week do you generally exercise? __________What types of exercise to you participate in? ______________________

Please list any difficulties you experience with your appetite or eating patterns:

____

Are you currently experiencing overwhelming sadness, grief, or depression? □ No □ Yes

If yes, for approximately how long? ____

Are you currently experiencing anxiety, panic attacks, or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? ____

Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: ____

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?____________________________________

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

What do you consider to be some of your strengths?

____

What do you consider to be some of your weaknesses?

What would you like to accomplish out of your time in therapy?