GRACE HUNTLEY
COUNSELING

Client Registration Form

Therapist: Grace Huntley, LMHC

Client Demographic Information

Patient Name:	**Preferred Name/Pronoun:**
Date of Birth:	**Email:**
Gender:	**Race/Ethnicity:**
Sexual Orientation:	**Social Security #:**
Mailing Address:	**Home Phone:** **Ok to leave a message?**
City, State, Zip Code:	**Mobile Phone:** **Ok to leave a message?**
Primary Physician:	**Psychiatrist (if any):**
Emergency Contact Person:	**Emergency Contact Phone:**

Relationship Status: **single/never** **partnered** **married** **divorced** **separated** **widowed**

Living Situation: **alone** **spouse/partner(s)** **parents** **roommate(s)** **children**

Name, age, and relationship of others in the home:

____

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Referral Source (how did you hear about me)

_____Internet Search _____Doctor/Other Therapist _____Friend/Colleague _____Therapist Database _____Other

Which are important focuses in your life? (Please check all that apply)

_____Relationships _____Family _____Parenting _____Sports

_____Education _____Legal/Probation _____Mental Health _____Occupation/Employment

_____Politics _____Adoption _____Religion _____ Other _______________

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With what communities do you identify or are you connected with? (Please check all that apply)

_____Women _____Men _____Transgender _____Lesbian _____Gay
_____Bisexual _____Queer _____Intersex _____Heterosexual _____Asexual
_____Disability _____Ethnic/Racial _____Religious/Spiritual _____ Class _____Recovery
_____Body Size _____Political/Activism _____Elder/Senior _____Youth _____Others

In the past 3 months have you experienced significant symptoms of? (Please check all that apply)

_____Aggression _____Dissociation _____Nightmares
_____Anger _____Emotional numbing _____Obsessive behavior
_____Anxiety _____Fear _____Panic
_____Apathy _____Flashbacks _____Phobias
_____Avoidance _____Guilt _____Self-blame
_____Behavior problems _____Harm or threat to others _____Self-destructive relationships
_____Crying _____Hyperactivity _____Self harm behaviors
_____Denial _____Hyperarousal _____Sexual acting out
_____Depression _____Insomnia/sleep problems _____Somatic (body) complaints
_____Difficulty concentrating _____Irritability _____Substance abuse
_____Disordered eating patterns _____Memory problems _____Other_______________________

Current Medications (prescribed/over the counter)	**Dosage/frequency**	**Prescribed by**	**Date 1st prescribed**	**Side effects**

Please add any other important information:

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Responsible Party is the person who will be paying the per-session fee for services
*Leave blank if same as patient

Responsible Party:	**Home Phone:**
Street Address:	**Work Phone:**
City, State, Zip Code:	**Mobile Phone:**
Relationship to Patient:	**Responsible Party SSN:**

Insurance Information

Primary Insurance:	**Policy Holder Name:**
Company Address:	**Policy Holder Date of Birth:**
City, State, Zip Code:	**Identification Number:**
Company Phone:	**Policy/Group Number:**
Employer:	**Policy Holder SSN:**
Secondary Insurance:	**Policy Holder Name:**
Company Address:	**Policy Holder Date of Birth:**
City, State, Zip Code:	**Identification Number:**
Company Phone:	**Policy/Group Number:**
Employer:	**Policy Holder SSN:**

Signature: ____

Date: _______________________________