Client Registration Form

Last name:	First:		Middle Initial:
Birthdate:	Alberta Health Care#:	Gender:	Age:
Street Address:	City:	Province:	Postal Code:
Home Phone:	Cell phone:	Work Phone:	
Physician:		Physician Phone:	

Background Information

Marital Status:

❑ Single ❑ Partnered ❑ Married ❑ Divorced * ❑ Separated * ❑ Widowed

Date of Marriage:	Date of Divorce:	Date of Separation:	Date of Death:

*Please describe parenting time/custody arrangements:

Presenting Problems

What concerns or problems, including symptoms, convinced you to seek help now?

_____

_____

_____

Have you sought out treatment for this problem before? ❑ Yes ❑ No If yes, who treated you?_____When?_____

Family Information

Spouse/ Partner: ❑ Yes ❑ No
Name:_____Age:_____

Children (names & ages): ❑ Yes ❑ No

Name:_____ Age:_____ Deceased? ❑ Yes ❑ No

Name:_____ Age:_____ Deceased? ❑ Yes ❑ No

Education

Highest grade completed in school: _____ Where:_____

Did you attend any Post-Secondary Institutions? ❑ Yes ❑ If yes, where/ When? _____

_____

Work History

Are you currently employed? ❑ Yes ❑ No If yes, are you working ❑ Full Time ❑ Part Time

Current Occupation: _____ Years on the job:_____

Past Occupation: _____ Years on the job:_____

Medical History

How is your present physical health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you have any recurrent or chronic health problems or conditions: ❑ Yes ❑ No If yes please describe:

_____

Are you currently under a physician's care for a physical problem? ❑ Yes ❑ No If yes, please describe:

_____

Do you presently take any medications on a regular basis? ❑ Yes ❑ No If yes, please complete the following

Name of medication	For what reason	Who prescribed

Have you ever had any of the following medical diagnosis or any condition or illness?

Yes	No	Diagnosis/Condition/Illness	During Childhood	Past as an adult	Currently
❑	❑	Allergies/ Asthma			
❑	❑	Headaches/Migraines			
❑	❑	Heart Problems			
❑	❑	High Blood Pressure			
❑	❑	Substance Abuse (alcohol, drugs)			
❑	❑	Thyroid Problems			
❑	❑	Head Injury or loss of consciousness			
❑	❑	Irritable bowel			
❑	❑	Vision Problems			
❑	❑	Hearing/ Chronic Ear Infections			
❑	❑	Sleep Problems			
❑	❑	Diabetes			
❑	❑	Cancer (Type: _)			
❑	❑	Epilepsy or Seizures			
❑	❑	Any other serious medical problems			

Mental Health History

Family History (child, siblings, birth parents, uncle's/aunt's, cousins, grandparents) for any of the following:

	Past (self)	Current(self)	Family Member
Abuse (sexual, physical, neglect)			
ADHD/ADD			
Anxiety/Panic/Phobias			
Autistic Spectrum			
Bipolar Disorder			
Depression			
Eating Disorders			
Explosive Temper			
Learning Difficulties			
Schizophrenia			
Sleep Disorders			
Other emotional difficulties			

Have you ever seen a psychiatrist? ❑ Yes ❑ No If yes, please complete the following

Who	When	For what reason

Have you ever been hospitalized for a psychiatric condition? ❑ Yes ❑ No If yes, When?_____
Please provide details:_____

Have you or any other family member ever been involved in therapy? ❑ Yes ❑ No If yes, when:_____

Issues Addressed:_____

Are you in treatment with another mental health provider at the current time: ❑ Yes ❑ No

If yes, provide name and telephone number: _____

If necessary, would other family member(s) be willing to attend therapy sessions? ❑ Yes ❑ No

How did you hear about us? _____

What are your goals for Therapy?

_____

_____

_____