Reina Remy, LCSW
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Client Registration Form

Please complete this form as fully as possible. *This information is **confidential*** and for our use only and will ***not*** be released to any person or group without your written consent. *Please print clearly.*

Client Information

Client's Name | *Date of Birth* | *Age*

Home Address: street, Apt.# | *City, Zip Code* | *If under 18yrs, name of Guardian*

Home Telephone # | *Work Telephone #*

Cellular Phone # | *Other #* | *Email*

Name of Emergency Contact | *Telephone #* | *Relationship*

Name of Referring Person

Briefly describe the concern or situation that brought you in today: _____

_____

_____

Responsible Party Information

Name of Responsible Party | *Date of Birth* | *Social Security No.*

Address: street, Apt.#, city, state, zip | *Phone #*

Primary Insurance Name | *Policy/Identification #* | *Group #*

Secondary Insurance Name (if applicable) | *Policy/Identification #* | *Group #*

Payment Authorization

I understand that it is my responsibility to pay for the fee established for professional services rendered to the above client. I hereby authorize payment of benefits directly to Reina Remy, LCSW.

Today's Date | *Signature of Responsible Party*

Family Information

Number of people in the client's current household: _____ Marital Status of Client: Single Married Committed Divorced Separated Widowed

Languages spoken if other than English: _____ Religious preference (Optional): _____

Please list client's immediate family including adult children and those not living with the client.

Name	Sex	Birth Date	Relationships	Home

Educational/ Occupational Information

Is the client currently a student? ____ YES ____ NO Name of last school attended: _____

Highest grade completed: _____ Highest degree and major: _____

Does the client have any learning difficulties? ____ YES ____ NO
If yes, please briefly describe:

_____

Is the client currently: ____ Employed ____ Unemployed ____ Retired ____ Other (please specify): _____

Occupation: _____

Health Information

_____ _____
Name of client's primary care physician *Physician's telephone number*

Is the client currently under at doctor's care? ____ YES ____ NO If yes, for what reason?

_____

_____

List current medications client is taking:

Medication	Dosage	Prescribed by

Has the client received past counseling or psychotherapy? ____ YES ____ NO If yes, whom did the client see?

Whom did the client see?	Dates	For what reason?

Has the client received other health care services? ____ YES ____ NO If yes, whom did the client see?

Whom did the client see?	Dates	For what reason?