RIVER CAIRN COUNSELING

Balancing Life's Chaos

REGISTRATION FORM

Please take a few moments to fill out the following information.

PERSONAL INFORMATION

Name: _____ Age: _____ Date of Birth: _____

Sex: Female_____ Male_____

Address: _____

City: _____ State: _____ Zip Code: _____

May I have permission to mail to this address? YES_____ NO_____

Telephone

(Contact will be attempted in order of numbers listed)

1. (_____) _____ - _____ (circle one) cell/home/work/other

2. (_____) _____ - _____ (circle one) cell/home/work/other

3. (_____) _____ - _____ (circle one) cell/home/work/other

May I have permission to leave a phone message? YES_____ NO_____

Is discretion needed when contacting or leaving a phone message for you? YES_____ NO_____

Email

(Please avoid using work emails as possible for your own confidentiality)

_____ (circle one) personal/work

Preferred form of communication: Telephone: _____ Email: _____

BACKGROUND INFORMATION

Relationship status:

Married _____ Single (Never married) _____ Separated _____

Divorced _____ Widowed _____

List all immediate family members and (optional) primary supports (i.e. extended family, roommates, close friends):

Name	Relationship	Age	DOB	Living with you?
				Y N
				Y N
				Y N
				Y N
				Y N
				Y N
				Y N

Emergency contact name: _____ Phone: (____)_____-_____

Education: (highest grade completed) _____

Employer: _____ Phone: (____)_____-_____

How long have you worked there? _____

HEALTH INFORMATION

Primary Physician: _____ Phone: (____) ____-_____

List any *current* significant health concerns (including physical and mental health):

_____

_____

_____

_____

List any *past* significant health concerns (including physical and mental health):

_____

_____

_____

_____

List any *family* health concerns, current or past (including physical and mental health):

_____

_____

_____

_____

List any substances you have used (alcohol, marijuana, caffeine, amphetamines, etc.):

Substance	Currently Used?	Age First Used	Frequency	Amount
	Y N			
	Y N			
	Y N			

Have you ever sought treatment for substance use? YES _____ NO _____

List any psychiatric medications:

_____ Dosage:_____ _____Current _____Past

_____ Dosage:_____ _____Current _____Past

_____ Dosage:_____ _____Current _____Past

_____ Dosage:_____ _____Current _____Past

_____ Dosage:_____ _____Current _____Past

Name of psychiatric medication provider: _____ Same as Primary Physician

If not same as Primary Physician: _____ Phone: (_____)_____-_____

Have you, a family member, or close friend ever attempted suicide? YES _____ NO _____

If yes, was it: Self _____ Family Member: _____ Friend: _____

How long ago: _____

Are you currently experiencing thoughts of suicide, homicide, or self harm? YES ____ NO ____

If yes: Self Harm thoughts: ____ Suicide thoughts: ____ Homicide thoughts: ____

TREATMENT INFORMATION

What is your primary reason for seeking services at this time?

_____

_____

_____

_____

_____

How did you hear about River Cairn Counseling services? _____