MORNING STAR PSYCHOTHERAPY ASSOCIATES
CLIENT REGISTRATION SHEET

Name:_____Date of Birth:___/___/___ Today's Date:: ___/___/___

Address: _____

City:_____ State: _____ Zip: _____

Work Telephone: (___) _____ Home Telephone: (___) _____

Sex: Male Female Cell Phone (___)-_____-_____

Employer/School: _____

Marital Status: Married Single Divorced Widowed

Emergency Contact:_____ Telephone:(___) _____ _____

Guardianship Information (if relevant):

Name:_____Address:_____ Phone:_____

Relevant medical conditions (history, current condition, changes in condition):

_____

_____

Medications (dosage, dates of initial prescriptions, name of prescribing professional):

_____

_____

_____

Allergies/adverse reactions to treatment:

_____

Primary Care Physician or Psychiatrist Name: _____

Address:_____ City_____ Zip_____

Reason for seeking counseling today (Include any prior history of counseling for mental health, alcohol or other drug problems): _____

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