CLIENT REGISTRATION FORM
Life Counseling Center, Inc.

Client Information

Client Name: _____ _____ _____ Today's Date: _____
Last First MI

Street Address: _____ City: _____ State:_____ Zip Code _____

Date of Birth: _____ Gender: _____ Marital Status: _____

Race: ☐ White/Caucasian ☐ Hispanic ☐ Black or African American ☐ American Indian or Alaska Native ☐ Other ☐ Decline

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Preferred Language Spoken: ☐ English ☐ Spanish ☐ Other: _____

Email: _____ Employer or School Name: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Preferred Method of Contact including Appointment Reminders

Primary Phone: _____ ☐ Text ☐ Voice Secondary Phone: _____ ☐ Text ☐ Voice

Parent / Guardian Information (If Client is a Minor)

Mother: _____ Birth Date: _____ Phone: _____

Father: _____ Birth Date: _____ Phone: _____

Other: _____ Birth Date: _____ Phone: _____
Step Parent/Guardian

Is there a custody agreement in place? ☐ Yes ☐ No
If yes, please provide a copy of the custody agreement, this will help us understand the arrangement made regarding your child's medical treatment.

Health Insurance

I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I authorize Life Counseling Center to release any medical information to my insurance carrier or third-party payer to facilitate processing my claims.

Primary Coverage

Insurance Name: _____ Policy #: _____ Group #: _____
Policy Holder Name: _____ Policy Holder Date of Birth: _____
Client Relationship to Policy Holder: _____

Secondary Coverage

Insurance Name: _____ Policy #: _____ Group #: _____
Policy Holder Name: _____ Policy Holder Date of Birth: _____
Client Relationship to Policy Holder: _____

Medical History (Physical and Mental)

Current Medications (including vitamins):_____

Known Drug Reactions or Allergies: _____

Have you been in therapy before? ☐ Yes ☐ No
If yes, who provided the therapy? _____
What were the issues addressed? _____
What was helpful? _____

Current Areas of Concern

Check all current areas of concern that apply:

☐ Abuse	☐ Divorce	☐ Insecurity	☐ Spiritual Issues
☐ Anger	☐ Eating Disorders	☐ Life Transition	☐ Substance Abuse
☐ Anxiety / Stress	☐ Family	☐ Parenting	☐ Suicidal Thoughts
☐ Behavioral Issues	☐ Finances	☐ Relationships	☐ Trauma
☐ Career / Job Loss	☐ Grief	☐ School / Education	
☐ Depression	☐ Health	☐ Sexuality	

Briefly explain the areas of concern for which you are seeking help: _____
_____

Who may we thank for referring you? _____

Primary Care Provider

Primary Care Physician: _____Phone: _____

Authorization of Release of Information
I, the client or legal parent/guardian, herby authorize Life Counseling Center to communicate directly with my primary care physician for evaluation, referral, planning, coordination of services, and discharge information for the client indicated on this intake form. This authorization can be revoked at any time and will automatically end within one year from the date I sign this form.

_____ (*Initials*) I authorize release as outlined ☐ I do not authorize release of information at this time

Client Rights and Notice of Privacy Practices

Life Counseling Center is required by U.S. federal law to maintain our clients' privacy and inform clients of their rights as consumers of our services. Our Notice of Privacy Practices and Client Rights can be found posted on our website, in the lobby and hallway of our facility, and you may request a paper copy from the reception staff at the front office.

_____ (*Initials*) I, the client or legal parent/guardian, acknowledge that I have reviewed a copy of Life Counseling Center's Notice of Privacy Practices and Client Rights.

Consent

I, the client or legal parent/guardian, certify that the information provided on this form is complete and accurate.

Printed Name: _____ Relationship to Client: _____

Signature: _____ Date: _____