

Keys to Living Counseling Center

Client Registration

Please fill out the following information form as completely as possible.

Name: _____ **Date:** ____/____/____

Date of Birth: ____/____/____ **Age:** _____ **Social Security #:** _____ - _____ - _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Employer: _____

Do we have your permission to: (Circle Yes or No)

1. Contact you via cell phone? If yes, cell number: _____ Yes ___ No ___
2. Leave a message on your home answering machine? Yes ___ No ___
3. Leave a message regarding appointment changes at your place of employment? Yes ___ No ___

Spouse: _____ **Date of Birth:** ____/____/____ **Age:** _____

Spouse's Employer: _____ **Work phone:** _____

Referred by: _____

Circle how first heard of Keys to Living: Friend, family member, pastor, radio, phone book, seminar, church
If you attend a church please identify: _____

Emergency contact:

In you need emergency care during a session at Keys to Living please give the name(s) of people (ie, spouse, family member, friend) who we could contact to assist you in getting to the appropriate care facility (ie, hospital)

Name _____ Phone (_____) _____

Name _____ Phone (_____) _____

Primary Care Physician Information

Primary Care Physician: _____ **Last med exam** ____/____/____

Physician aware you are seeking counseling at this time? Yes ___ No ___

___ Initial I do not have a current physician.

___ Initial I do not want information released to my physician.

___ Initial I would like to complete a release of information form permitting my therapist and physician to exchange information related to my case. I understand that signing this form is not mandatory. Please read and sign the release on the back of this form if you initialed this section.