BLUE DOOR PSYCHOTHERAPY

Adult Registration

Client Information

Name of Client:_____

Date of Birth:_____ Sex: F M

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Home telephone number: _____(May I leave a message at this number? Yes No)

Alternative telephone number:_____

Email:_____

Emergency Contact:_____ Relationship to Patient:_____

Telephone:_____ Address:_____

Current Medications:_____

If this is for relationship work: Adult Client #2 Information

Name of Client:_____

Date of Birth:_____ Sex: F M

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Home telephone number: _____(May I leave a message at this number? Yes No)

Alternative telephone number:_____

Email:_____

Emergency Contact:_____ Relationship to Patient:_____

Telephone:_____ Address:_____

Current Medications:_____

Referred by: _____

May I thank this person for referring you? Yes No

Financial Information:

Responsible party:

Name: _____

Mailing Address: _____

Family Information:

People living in the home:

Name	Relationship	Age

Treatment Information:

Briefly describe your primary concerns related to your request for treatment:

_____

_____

_____

_____

_____

To coordinate care may I exchange information with your PCP or Psychiatrist? If yes, please provide their full names and contact information:

_____

_____

_____

Please list any other mental health professionals with whom you are currently working who were not listed above:

_____