



REGISTRATION FORM

Today's Date: _____ What would you like me to call you: _____

Client name: _____

Date of birth: _____ Age: _____

Home phone: _____ Cell: _____

Minor client cell: _____

Street Address: _____ City: _____ Zip: _____

Email: _____

Minor email: _____

**Please note: Email correspondence is not considered to be a confidential medium of communication. When therapist uses email details will be limited. If you would rather not use email please let therapist know.*

Personal Physician: _____ Phone Number: _____

Psychiatrist: _____ Phone Number: _____

Emergency contact:

(This name will be used in case of an emergency and is assumed that a release of information has been signed to include this name. Please remember to complete a release of info form.)

Name: _____ Relationship: _____

Contact number : _____

The above information is true to the best of my knowledge.

Signature: _____ Date: _____