Date:_______________________ **Judith Peletz, LMFT**

New Client Registration

YOUR NAME:_______________________________________ Social Security Number: ______-______-______

Date of birth: _____/_____/_______ Age:_________

Address:_________________________________ City:_______________ Zip:____________

Home Phone: (________)______________________ Work: (________)______________________

Cell Phone: (________)______________________ Other: (________)______________________

E-mail (print neatly!):___________________________ Alternate e-mail:______________________

Gender Identity_____________________________ Preferred pronouns______________________

Occupation:______________________ If employed, employer name:______________________

Preferred method of contact (can check more than 1): cell phone____ home phone____ e-mail____ text____ work phone____

SPOUSE OR SIGNIFICANT OTHER ***(complete even if s/he is not participating in therapy)***

Name:_______________________________

Date of birth: _____/_____/_______ Relationship status: _______________

Address (if not living with you):___________________________ City:_______________ Zip:________

Home Phone: (________)______________________ Work: (________)______________________

Cell Phone: (________)______________________ Other: (________)______________________

Occupation:______________________ If employed, employer name:______________________

Who else lives in your home? Name_______________________ Age:______ Relationship:______________

Name_______________________ Age:______ Relationship:______________

Name_______________________ Age:______ Relationship:______________

Name_______________________ Age:______ Relationship:______________

Any children who live outside the home? (give names and ages)______________________________

Insurance Plan:_____________________________ Identification number______________________

Full Name of primary insured:_____________________________

If primary insured is not you, give their date of birth: ____/____/_____ **and their employer:**__________________

Emergency Contact: ____________________ Phone:(_____)__________ Relationship:____________

Primary Doctor::_________________________________ Phone: (______)__________________

Doctor's address:_________________________________ City:______________________

Psychiatrist (if any): _________________________________ Phone: (______)__________________

Psychiatrist's address:_________________________________ City:______________________

Health Issues/Allergies: ____

____

Medications and Over-the-Counter Drugs taken regularly (include dosages and why you take them):______________

____

____

Who referred you to my practice? ____________________________ **Did you look at my website before coming?**________

Anything else you would like me to know?____

Feel free to attach additional pages.