SouthSHORE
COUNSELING

Client Registration Form

Client Name_____Date_____

Date of Birth_____Social Sec. #_____ Gender Identification_____

Parent / Guardian / Legal
Representative_____

**If patient is under 18-Do you have full custody of child? (circle one) Yes or No

If No-please list legal guardian/parent

_____

Address_____

Apt._____City _____ State_____ Zip Code_____

Primary Phone #1 _____ Phone #2 _____

Occupation _____ Employer _____

Reason for seeking counseling at this time:

_____

Do you have any serious medical problems or infectious
diseases?_____

Current
Medication_____

Marital Status (circle one): Single Engaged Married Separated Divorced Widowed Cohabitating

For how long?_____Partner's name_____

Religious Affiliation_____Race/Ethnicity/Tribe_____Nation
of Origin_____ Length of Time in US _____

Previously seen (circle all that apply): Psychiatrist Psychologist Counselor Therapist:

List names and
dates_____

Insurance Company _____Policy ID_____Group #_____

Policy Holder _____ DOB _____ Social Sec_____

Relationship to client_____

Emergency Contact: Name and Phone
number_____

N91W17194 Appleton Ave, Suite 204
Menomonee Falls, WI 53051
P 414-502-7780
W www.southshorecounseling.org

9735 W St. Martin's Rd
Franklin, WI 53132

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Who referred you?_____

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