Beth Powell's

In-Family Services

Trauma-Informed Psychotherapy,
Licensed Clinical Social Work and Neuro-Behavioral Education

REGISTRATION FORM

Date _______________ Form completed by _________________________

Client Information:

Name ___________________________ D.O.B __________ Age ____ Gender ____

Race/Nationality________________ Height _________ Weight________

Current physical health problems/diagnoses ____________________________________

____

____

Past physical health problems/diagnoses ____

____

____

Current medications for physical health ____
Current mental health diagnoses ____
Past mental health diagnoses ____
Current medications for mental health ________ _________________________________
Have any disabilities that you know of? ____

____

Profession ____
Place of employment ____
Home town and state ____
Level of education ____
Currently in school? Where? ____

____

Primary Support System Information

____
Name Relationship to Client

____
Name Relationship to Client

____
Name Relationship to Client

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SW License 18222

Family information

Spiritual affiliation ____

Others living in home:

Name	Sex	Age	Relationship to Client

What therapies do you currently undergo? ______________________________

What therapies and/or hospitalizations have you undergone before?

Do you smoke?

Y N How much? ____

Do you drink?

Y N How much? ____

Do you use street drugs of any kind?

Y N What do you use and what is the frequency?______________________

Do you use over-the-counter medications?

Y N What do you take, and what is the frequency and dosage? _____________

What are your hobbies and interests?

Please describe areas of concern for which you are seeking help:

Note: Please attach summaries of prior assessments relevant to this evaluation.

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