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Kingwood, TX 77339
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(281) 812-3777 (fax)
captassociates.com

Client Registration

Today's Date: _____

Name: _____ S.S.#_____
Date of Birth: _____ Age: _____ Male ____ Female_____
Address: _____
City/State/ZIP: _____
Employer/School: _____ Occupation: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____
Where do you prefer to receive calls? ___Hm___Cell___Wk May we leave you a message? ___Yes ___No
May we contact you by e-mail ___Yes ___No E-mail address_____
Children who live in the home:
Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____

If client is a minor:

Mother's Name: _____ Home Phone: _____
Work Phone: _____ Cell Phone: _____
Father's Name:_____ Home Phone: _____
Work Phone: _____ Cell Phone: _____

If seeking couples counseling:

Spouse/Partner :_____S.S.#_____
Date of Birth: _____ Age: _____ Male ____ Female_____
Address: _____
City/State/ZIP: _____
Employer/School: _____ Occupation: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Where do you prefer to receive calls? ___Hm___Cell___Wk
May we leave you a message? ___Yes ___No May we contact you by e-mail ___Yes ___No
E-mail address_____

Emergency Contact

Name: _____Relationship: _____
Address: _____ Phone: _____

Health Information

Please list any medical conditions you feel the therapist should be aware of: _____
_____
_____
Please list any medications you are currently taking, including the dosage: _____
_____
_____
Have you (or your spouse/partner-if applicable) ever seen a mental health provider? ____Yes ____No
If yes, who: _____ when: _____

Referred by:

Name: _____
Address: _____
May we send a thank you card to this referral with your name included? ___Yes ___No

Goals: What are your goals for therapy? _____
_____
_____
_____
_____