MINDINGMATTERS CLIENT REGISTRATION FORM

NAME: _____ GENDER ID _____

STREET:_____

CITY: _____ ST: _____ ZIP_____

PHONE: (Cell) _____(H)_____

EMAIL: _____ DOB _____

MARITAL/RELATIONSHIP STATUS: _____

EMERGENCY CONTACT: _____

Please indicate whether it is acceptable to leave a message on your home or cell # H: **[ ]** C: **[ ]**

MENTAL HEALTH HISTORY: (please indicate dates of service, type of service, and a list of medications if applicable).

_____

_____

_____

MEDICAL HISTORY: (please indicate dates of service, type of service, and a list of medications if applicable)

_____

_____

_____

_____

Client Signature:_____ Date: _____

Payment is expected at time of service. Minding Matters does not participate in any third-party payment contracts. Your signature on this document is confirmation that you have read, and agree to, the HIPAA guidelines http://mindingmatters.com/counseling-services/.