Date:_____ **Clarence Cisneros-Jones, LCSW 94006**

New Client Registration

YOUR NAME:_____ Social Security Number: _____-_____-_____

Date of birth: _____/_____/_____ Relationship status: _____Height: ____'____" Weight_____

Address:_____ City:_____ Zip:_____

Home Phone: (_____)_____ Work: (_____)_____

Cell Phone: (_____)_____ Other: (_____)_____

E-mail (print neatly!):_____ Alternate e-mail:_____

Occupation:_____ If employed, employer name:_____

If in relationship, how long? _____ Previously married? _____If so, how often, and how long?_____

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

Name:_____ Social Security Number: _____-_____-_____

Date of birth: _____/_____/_____ Relationship status: _____Height: ____'____" Weight_____

Address (if not living with you):_____ City:_____ Zip:_____

Home Phone: (_____)_____ Work: (_____)_____

Cell Phone: (_____)_____ Other: (_____)_____

E-mail:_____ Alternate e-mail:_____

Occupation:_____ If employed, employer name:_____

Previously married?_____ If so, how often, and how long?_____

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:_____ **Full Name of primary insured**:_____

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

Emergency Contact (not partner): _____ 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):_____

_____

Alcohol: Average number of drinks per week_____ Average number of drinks when you drink:_____

Marijuana / other non-prescription drugs (drug you use, how much use, how often): _____

Has anyone ever been concerned about your alcohol or drug use?_____ If so, who?_____

Cigarettes: Average use per day:_____ Desire to quit?_____

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

Word or sentence to describe your life or how you feel:_____