

NEW TEEN CLIENT REGISTRATION FORM

Maureen R. Johnston, MFT
1101 S. Winchester Blvd., #A-101, San Jose CA 95128

TEEN CLIENT INFORMATION

NAME _____ AGE _____ DATE OF BIRTH _____

ADDRESS _____
Street Apt. # City State Zip code

HOME PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____ SOCIAL SECURITY # _____

SCHOOL _____ GRADE _____

PARENT INFORMATION

NAME _____ AGE _____ DATE OF BIRTH _____

ADDRESS (if different) _____
Street Apt. # City State Zip code

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____ SOCIAL SECURITY # _____

PLACE OF EMPLOYMENT _____ OCCUPATION _____

INCOME _____ MARITAL STATUS _____ HIGHEST GRADE COMPLETED _____

I occasionally send out announcements for classes/workshops I run, may I add your name to my personal, confidential mailing list? _____

OTHER MEMBERS OF THE HOUSEHOLD

Name	Age	Relationship to client
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

GOALS FOR THERAPY _____

Has your teen had previous counseling experience? _____ When, why and where? _____

REFFERAL SOURCE _____ May I thank them for the referral? _____

INSURANCE COMPANY _____ NAME OF INSURED _____

AUTHORIZATION/CERTIFICATION NUMBER _____

EMERGENCY CONTACT _____ PHONE # _____ RELATIONSHIP _____

SIGNATURE _____ DATE _____