LEGACY COMPREHENSIVE COUNSELING & CONSULTING
19751 E. MAINSTREET SUITE 215 - PARKER CO 80138
WWW.LEGACYPARKER.COM - PHONE: 303-841-4005
OR INFO@LEGACYPARKER.COM

Patient Registration Form

PATIENT INFORMATION

Date: _____

Last Name: _____ First Name: _____ MI: _____

Birthdate: _____ Gender: _____ Occupation: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

List all Phone #'s you authorize Legacy to leave you messages: _____

E-mail: _____

I authorize Legacy to send Newsletters and/or program updates via e-mail and/or mail: ____ Yes ____ No

INSURANCE DATA

Insurance Company Name: _____ ID #: _____

Policy Holder Name: _____ Group #: _____

Policy Holder DOB: _____ Employer: _____

Policy Holder Social Security #: _____ Insurance Phone Number: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

REFERRAL INFORMATION

Referral Source_____

Briefly describe the reason for the referral:_____

_____

_____

_____

FAMIY HISTORY

List family members living in your home:

Name	Gender	Age	Relationship to Patient

Are there learning or education problems with any of your siblings, parents, extended family? Please describe the nature of problems? _____

_____

_____

Are there mental health problems with any of your siblings, parents, extended family? Describe the nature of problems? _____

_____

_____

Are there behavior problems with siblings, parents, extended family? _____

_____

_____

MEDICAL HISTORY

Provider Prescribing Medication: _____ Phone Number: _____

Medication			
Type	Dosage	Date Began	Date Ended

Describe any significant illnesses, surgeries, head injuries, and/or allergies: _____

_____

_____

_____

_____

Physician's Name: _____

Physician's Address: _____Phone #: _____

List concerns regarding your vision: _____

List concerns regarding your hearing: _____

TREATMENT HISTORY

Evaluation/Counseling Provider	Type of Service (e.g., counseling, occupational therapy, physical therapy, speech therapy, etc.)	Dates of Service

BEHAVIOR HISTORY

Concerns regarding your sleep patterns: _____

_____

Concerns regarding your appetite: _____

_____

List some of your strengths: _____

_____

Describe your typical mood: _____

_____

List your main counseling and treatment goals:

1. _____

2. _____

3. _____