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

Family / Couples Registration Form

ADULT INFORMATION

Name: _____ DOB: _____

Address: _____ City: _____ Zip: _____

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

Employer: _____ E-mail: _____

Name: _____ DOB: _____

Address: _____ City: _____ Zip: _____

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

Employer: _____ E-mail: _____

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: _____

_____

_____

_____

_____

CHILDREN'S INFORMATION

Name	DOB	Gender	Specific Concerns, if any

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

_____

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

_____

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

_____

Please describe custody arrangements of patient, if applicable. Indicate who has mental health decision power.

_____

_____

Is there any current DCS (Department of Child Services) involvement: _____

If yes, DCS Caseworker: _____ Briefly describe DCS involvement:_____

_____

_____

MEDICAL HISTORY

Family Member	Describe significant illnesses, surgeries, head injuries, and/or allergies

Medication Information

Family Member	Medication	Dosage	Prescribing Physician	Purpose of Medication

FAMILY TREATMENT HISTORY

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

List your main counseling and treatment goals for your child and/or family

1. _____

2. _____

3. _____

Which family members need to participate in family sessions?

_____
_____
_____

What will best encourage participation by all members?

_____
_____
_____