CROSSROADS
Affordable Counseling of North Texas

Glenn T. Howard, M.Div. LMFT, AAPC

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Client Registration Information

Date:________________ Referred by:_______________

Name: _____________________________ Sex: ____Male ____Female

Address:____________________ City:_______________ State:___ Zip:_____

Home Phone: ____________ May I call you at home? ___Yes ___ No

Work Phone: _____________ May I call you at work? ___ Yes ___ No

Cell: ____________________ e-mail:__________________________________

Age:______ Birth Date: ___/___/___ Social Security Number_____________

Employer: _______________________ Occupation: ____________________

Address:___________________ City:_______________ State:___ Zip:______

Married:___Yes ___No # of years____ **Spouse**:_______________________

Spouse Employed by :___________________ Occupation:_________________

Address:___________________ City:_______________ State:____ Zip:_____

Work Phone: _____________ May I call you at home? ____Yes ____No

Cell: ____________________ May I call you at work? ____ Yes ____ No

Age: ____ Birth Date: ___/___/___ Social Security Number_______________

Emergency Contact: ______________________ Phone Number:___________

Person Responsible for Payment: _____________________________________

Address:_____________________ City:_____________ State:____ Zip:______

Names/Ages of all living in home:________________________________

____

What concern(s) bring(s) you to counseling at this time?____________

____

____

____

What changes would you like to see as the result of counseling? ________

____

____

____

Please any previous counseling experiences:

1. ______________________________ Helpful? ____ Yes ____ No

2. ______________________________ Helpful? ____ Yes ____ No

3. ______________________________ Helpful? ____ Yes ____ No

4. ______________________________ Helpful? ____ Yes ____ N0

Past Hospitalizations—Medical, Psychiatric, Chemical Dependency:

Dates: ________ Hospital: __________________Reason:____________

Dates: ________ Hospital: __________________Reason:____________

Dates: ________ Hospital: __________________Reason:____________

Are you under a doctor's care? ____ Yes ____ No Physician____________

List any medical conditions:____

List all current medications:____

Please list any other information you feel is important for me to know at this time:

____

____

____

Consent for Treatment:

I authorize and request **Glenn T. Howard** to carry out education or counseling evaluations/diagnostic assessments, treatment, and/or diagnostic procedures which now, or during the course of my treatment become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, **Glenn T. Howard** can make no guarantees about the outcome of my treatment. Further, the therapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between **Glenn T. Howard** and me. **Initial here:** ______

______________________________ ____________
Client/Parent/Guardian Signature Date

______________________________ ____________
Spouse Date

______________________________ ____________
Glenn T. Howard Signature as needed Date