Relational Advantage

Live, Work and Relate Well

PATIENT REGISTRATION – MINOR / DEPENDENT

Please complete this questionnaire and bring it to the first appointment. Please complete a separate form for each person participating in counseling.

Personal Data Today's Date _____

Name _____ Primary Phone_____ (Circle: Patient / Parent / Guardian)

Address _____ Home Phone _____ OK to leave messages? Y N

City_____ ST_____ Zip_____ Cell/Other Phone _____ (Patient / Parent / Guardian)

Date of Birth _____ Age _____ Sex ____ E-Mail (for appointment reminders) _____

Name of School _____ Grade _____ Teacher or Counselor _____

What does the patient like or dislike about school? _____

Family Physician _____ Phone _____

Emergency Contact / Relationship _____ Phone _____

Please list where patient was born and the last two cities/states patient has lived in:

Place of Birth _____

City/State _____ From (date) _____ To _____

City/State _____ From (date) _____ To _____

Parents/Guardians Status and Information

____ Married to each other since (year)_____ and living together - OR - ____ Separated ____ Divorced How long? _____
____ One or both deceased Which parent? Mother Father When?_____ Cause of death _____

Mother/Guardian Name _____ Date of Birth _____

Street Address _____ Phone _____

City/ST/Zip _____ Work Phone _____

Employer _____ Job Title _____

Spouse (if different from Father) _____ Date of Birth _____

Father/Guardian Name _____ Date of Birth _____

Street Address _____ Phone _____

City/ST/Zip _____ Work Phone _____

Employer _____ Job Title _____

Spouse (if different from Mother) _____ Date of Birth _____

Medical and Psychological History

Brief comment regarding reason for counseling: _____

_____

Current Medical Problems _____

Current Medications _____

Has the patient received professional or pastoral counseling within the last five years? Y N

With Whom? _____ When? _____

Has the patient ever been hospitalized for a psychological condition? Y N Hospital _____

Explain _____ Dates _____

Does the patient currently have trouble sleeping? Y N Describe _____

Appetite/Eating Habits: Good Poor Eats when not hungry Other _____

Any recreational drug or alcohol use you're aware of? Y N How much/how often? _____

Family Constellation

List siblings according to birth order (include step, half, adopted and foster siblings) and indicate if they live in patient's home:

Names	Date of Birth	Age	Sex	Birth/Step/Adopted/Foster	In Home
_____	_____	_____	___	B / S / A / F	Y / N
_____	_____	_____	___	B / S / A / F	Y / N
_____	_____	_____	___	B / S / A / F	Y / N
_____	_____	_____	___	B / S / A / F	Y / N
_____	_____	_____	___	B / S / A / F	Y / N

How does the patient get along with other family members? _____

Anything else the therapist should know about the patient? _____

_____

Parent / Legal Guardian's Permission to Treat a Minor:

I hereby grant permission for (circle one) Dr. Todd Linaman or Kristen Linaman-Weleba to provide counseling services to my child / dependent.

Signature _____ Date _____

Printed Name _____ Relationship to patient _____

We were referred to Relational Advantage, Inc. by: ___ Employer ___ School ___ Pastor (Church _____)
____ Other _____

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