120 East Main St., Suite 200, Aspen, CO 81611
970-620-9377
info@aspenalliancecounseling.com

Client Registration Form

Name | Date of Birth | Age

Home Address | City | State | Zip Code

Home Phone | Work Phone | Cell Phone (Text: Y/N) | Email Address

Parent/Guardian Name (if applicable) | Relationship to Client | Phone Number

Parent/Guardian Home Address | City | State | Zip Code

Place of Employment/School

Marital-Partner Status | How Long? | Ages of Children

Are you seeking services for a minor child (under the age of 15): YES NO

I, _____ (name of parent/guardian), authorize Aspen Alliance Counseling to provide mental health services to the above-named minor child. I understand that for children under the age of 15, only the parents or other person with medical decision-making authority may authorize treatment. I have the authority to authorize treatment for the above-named minor child.

Parent/Guardian Signature | Date

Have you had pervious therapy or counseling? (circle one) YES NO
If yes, please briefly explain and indicate where:

Are you currently under a physician's care? (circle one) YES NO
If yes, please specify and list any medications taken:

Primary Care Physician's Name Phone Number

May I identify myself if I call your home? (circle one) YES NO Your work? YES NO
I accept text messages: YES NO Preferred method of communication: _____

Name of Person to Notify in Emergency Relationship to Client

Address of Emergency Contact City State Zip Code Phone Number

What is your primary reason for seeking counseling?

How did you hear about us?

_____ (please initial) I have received a copy of the HIPAA Privacy Practices and Patient Rights.

I understand this information will be part of my confidential file with Aspen Alliance Counseling, LLC

Client Signature(s) Date

Parent/Guardian Signature (if applicable) Date

Witness Signature Date