Through the Trees Therapy
GO THROUGH IT TO GET TO IT

Client Registration Form

Today's Date:				
Last Name:	**First Name:**	**Middle Init:**	**Date of Birth:**	**Age:**
Sex:	**Gender:**	**Sexual Orientation:**		**Personal Pronouns:**
Address:	**Apt. #**	**City:**	**State:**	**Zip Code:**
Occupation:	**Employer:**	**Length at Job:**		**Email Address:**
Contact Information:		**Preferred way of Contact:** (phone, text, email)		
Racial Identity:		**Religious/Cultural Considerations:**		

Relationship Status:

- Single ☐
- Married ☐
- Divorced ☐
- Widowed ☐
- Separated ☐

Therapy History:

Individual ☐ Couples ☐ Group ☐ IOP ☐
PHP ☐ Inpatient ☐

How long were you in therapy?

Have you been to therapy for this challenge before?

Yes ☐ No ☐

cj@throughtreestherapy.com
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phone: (720) 614-2339

Name of Partner: **Children:** (names, ages)	**Are you currently experiencing suicidal/homicidal ideation?** **Yes** ☐ **No** ☐ **Is there a current plan, intention, and/or means to complete suicide/homicide?** **Yes** ☐ **No** ☐ **Is there a history of experiencing suicidal/homicidal ideation?** **Yes** ☐ **No** ☐ **How long ago was this ideation experienced?**

In Case of Emergency		
Name of local friend or relatives:	**Relationship:**	**Phone #:**
1.		
2.		

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Name of Insurance:	Member ID:	Group #:	Co-payment:

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