

**Tamra L. Hughes, MA, LPC  
Licensed Professional Counselor**

REGISTRATION FORM

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Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone (home): \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone (work): \_\_\_\_\_

County: \_\_\_\_\_ Phone (other): \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

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Relationship status:

married     common law     single (never married)     divorced     separated

non-cohabitating partner     cohabitating partner     widowed

Name of Partner/Wife/Husband: \_\_\_\_\_

Name(s) of children and ages: \_\_\_\_\_

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Name of present employer: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

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Present Health Concerns: \_\_\_\_\_

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Medications: \_\_\_\_\_  
\_\_\_\_\_

Past significant illnesses, injuries, or disabilities \_\_\_\_\_  
\_\_\_\_\_

Hospitalizations: \_\_\_\_\_  
\_\_\_\_\_

What is the primary concern or problem for which you are seeking help? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous Counseling: \_\_\_\_\_  
\_\_\_\_\_

If yes, please note any way that previous therapy was helpful \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referred by \_\_\_\_\_