Interwoven
Community Counseling Center

REGISTRATION FORM

CLIENT INFORMATION

Client Name	Date of Birth	Date of Registration
Client's Gender Pronouns	Gender Identity ☐ M ☐ F ☐ Other: ___________________________	
Client's Address (Street, City, State, Zip)	Client's Phone	Client's Email
If client is a minor, parent/guardian name (and address if different)	Parent's Phone (if different)	Parent's Email (if different)

Anticipated method of payment

☐ Self-Pay ☐ Medicaid- Medicaid #: ___________________ ☐ Insurance Name: ___________________________________

EMERGENCY CONTACT INFORMATION

Emergency Contact Name	
Relationship to Client	Phone Number

SERVICES REQUESTED

☐ Psychological Evaluation ☐ Individual Therapy ☐ Family Therapy ☐ Couples Therapy

REASON SEEKING SERVICES

TELEHEALTH SERVICES

☐ I am interested in telehealth services through Zoom (a HIPAA-compliant videoconference platform).
☐ I am interested in phone sessions.
☐ I am interested in attending sessions in-person.

AVAILABILITY

Mondays	Tuesdays	Wednesdays	Thursdays	Fridays
☐ Morning	☐ Morning	☐ Morning	☐ Morning	☐ Morning
☐ Afternoon	☐ Afternoon	☐ Afternoon	☐ Afternoon	☐ Afternoon
☐ Evening	☐ Evening	☐ Evening	☐ Evening	☐ Evening

How did you hear about Interwoven Community Counseling Center?