Austin Wellness PLLC

Austin Wellness, PLLC
www.austin-wellness.com
10010 Anderson Mill Rd.
Austin Texas 78750
512-257-0050

Registration Information-Adult

Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Ph: _____ Home Ph: _____ Cell Ph: _____

Email: _____

Date of Birth: _____ Gender: _____ Social Security #: _____
Marital Status: __ Single __ Married __ Divorced __ Widowed __ Separated __ Other

Occupation: _____

Client Employed by: _____ Ph: _____

Spouse/Partner Name: _____ Date of Birth: _____

Spouse Employed by: _____ Ph: _____

Insurance Information:
Name of Insurance: _____ Insurance Ph: _____

ID# _____ Group # _____

Policy Holder Information:
Name: _____ Date of Birth: _____

Social Security #: _____ Employer: _____

Client Relationship to Policy Holder: _____

Emergency Information:
In case of emergency, who should be notified? _____
Ph: _____ Relationship to Client: _____
Who referred you: _____

Last Name: _____ First: _____ Middle: _____

Medical History:
Are you currently under medical care: ___Yes ___ No

If yes, please indicate reason: _____

Physician's Name: _____

List any prescription or non prescription medication(s): _____
_____

Other significant medical history: _____

Counseling History:
Have you ever received psychotherapy/counseling? ___ Yes ___ No

Name/Dates/Location: _____
_____

Do you currently have a psychiatrist? ___ Yes ___ No

Psychiatrist's Name: _____ Ph:_____

Education:
Highest Level of Education: _____
Professional Training: _____
Other: _____

Family Information:
Parents: *Mother* ___ Living, age ( ) ___ Deceased
Father ___ Living, age ( ) ___ Deceased

Children: ___ Yes ___ No
Name(s) and Age(s): _____
_____