Austin Wellness PLLC

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

Registration Information _ - Child/Adolescent _

Parent/Guardian: _____ Today's Date: _____
Address: _____
City: _____ State: _____ Zip: _____

Work Ph: _____ Home Ph: _____

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: _____
Who referred you: _____

Child/Adolescent Information

Name: _____ Age: _____
Address: _____
City: _____ State: _____ Zip: _____

Home Ph: _____ Child's Date of Birth: _____ Child's SS #: _____
Adopted? ___ yes ___ no
Child lives with:
___ both parents/1 home ___ both parents / 2 homes ___ 1 parent (specify) _____
___ other relative _____ ___ other arrangement _____
Do you have the legal right to seek mental health treatment for this child? ___ yes ___ no
If no, do you have permission to seek such treatment? ___ yes ___ no
Child's grade: _____ Name of School:
_____

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?
Last Name: _____ First: _____ Middle: _____

Ph: _____ Relationship to Client: _____

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 for the client:
Mother ___ Living, age ( ) ___ Deceased
Father ___ Living, age ( ) ___ Deceased
Siblings:
Name(s) and Age(s): _____
_____

Does the client have children: Yes ___ No ___ other: _____