Child Focus, Inc.
Adult Outpatient Registration

Office Use Only (Registration Worker)					
Registration Date:		1st Appointment Offered:			
		Fee Code (Medicaid, Private Insurance Company, Fee):			
911/DI Worker:	DATE:				
		Case #:			
			Group:		Individual

Please Print. Please read and complete ALL sections.

Client's Information		
Last Name:	First Name:	Middle Name:
SS#:	Date of Birth:	
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	
Military Status: ☐ No ☐ Yes (specify): ____________________ ☐ Active ☐ Inactive		
Primary language if other than English:		
Person to Contact in case of an Emergency:		
Relationship:	Phone #:	

Current Living Situation (check all that apply)			
	Own Home		Friend's Home
	Relative's Home		Homeless
	Client's Race: (Check All that apply):		**Client's Ethnicity: (Check All that apply):**
	Asian (A)		Puerto Rican (A)
	Black/African American (B)		Cuban (C)
	Alaskan Native (M)		Mexican (B)
	Native American/American Indian (N)		Other Hispanic (D)
	White (W)		Not Hispanic or Latino (E)

Names and Ages of Your Children:				
Full Name:	Age:	Relation:	Does this child live with you?	
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No

Other Human Service Providers Involved with Client (check all that apply):		Caseworker's Name
	Children's/Human Services	
	Family Relations Court	
	Mental Health or other Health	
	Adult probation/parole	
	County DD	
	Other (specify):	

Client's Disabilities (check all that apply):			
	Communication Disorder		Physical Disability
	Visually Impaired		Hearing Impaired
	None		Other (specify):

Who referred you to Child Focus? (Check Only One)

	Self
	Heath care provider
	AOD provider
	County Human Services
	Court

	Other Community Referral
	School/Education
	Employer/EAP

Name of Person or Agency that Referred you to Child Focus:

Phone Number of Person or Referring Agency:

What is bringing you here today? Please explain your current issues in writing and your service provider will review what you have written.

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Client Date

(Office Use Only) (Clinican)

DSM IV		
	Number #	**Dx Name**
Dx1		
Dx 2		

Client's Global Assessment Score (1-100):_______________ Duration:_______________months