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:
Preferred Name:	Preferred Pronouns:	Sex:
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):**
	Alaskan Native		Cuban
	Asian		Mexican
	Black/African American		Puerto Rican
	Native American/American Indian		Other Hispanic
	Native Hawaiian/Other Pacific Islander		Not Hispanic or Latino
	White		
	Biracial		

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 Community and Human Service Providers Involved (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		Service Animal Assistance Needs
	Visually Impaired		Other (specify)
	Hearing Impaired		None
	Physical Disability		

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.

_____

_____

_____

_____

_____

_____ _____

Client Date

Office Use Only for Crisis Services and/or Diagnostic Testing (Clinician)

	ICD 10 Code	DSM V Diagnosis
Dx1		
Dx 2		

Client's Global Assessment Score (1-100):_____ Duration: _____months