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REGISTRATION FORM

Section I:	Client Information	Date _____
Name: _____ I Prefer to be called: _____		
Address: _____ City: _____ State: _____ Zip _____		
Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____		
The best time to contact me is: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. on my <input type="checkbox"/> Home phone <input type="checkbox"/> Work phone <input type="checkbox"/> Cell phone		
Date of Birth: _____ Social Security Number: _____		
Check Appropriate Box: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		
If Student, Name of School _____ City/State _____ <input type="checkbox"/> FT <input type="checkbox"/> PT		
Spouse or Parent's Name: _____ Employer _____ Work Phone _____		
Whom may we thank for referring you? _____		
Person to contact in case of emergency _____ Phone _____		
Email Address _____ Would you like to receive our e-newsletter? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Section II	Responsible Party
Relationship to Client: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Name: _____ Relationship to Client: _____	
Address: _____	
City: _____ State: _____ Zip: _____ Phone: (____) _____	
Employer _____ Work Phone (____) _____ Date of Birth _____	

Section III	Spouse/Partner/Children Information for Couples or Family Therapy/Coaching
Name of Spouse/Partner _____	
Address _____ City _____ State _____ Zip _____	
Birthdate _____ Best Phone Number _____	
Employer _____	
Child(ren):	
Name _____ Age _____ Birthdate _____	
Name _____ Age _____ Birthdate _____	
Name _____ Age _____ Birthdate _____	

Client Signature _____ Date _____

Spouse/Partner Signature _____ Date _____