Victoria Mental Health Services Ltd.
Greg Walsh, LICSW
1600 Arboretum Blvd., Ste. # 211
Victoria, MN 55386
Phone: 952-443-3970

Client Registration Form

Today's Date: _____Who referred you to Victoria Mental Health Services? _____

First Name: _____ M.I. ____ Last Name: _____Date of Birth: _____

Gender: (circle one) Male Female Address: _____

City: _____ State: _____ Zip Code: _____

***Please list only the numbers that we have permission to call.** Phone: (H) _____

(W)_____ (C) _____**If minor**, pls. list parent/guardian phone number/s (C)_____ (W/H) _____

Can we identify ourselves by using the clinic name? ( ) Yes ( ) No May we leave a message? ( ) Yes ( ) No

** If not, please indicate how you prefer we should identify ourselves??_____

Marital Status: (circle one) Never Married Separated Divorced Widowed Other

Employment: ( ) Employed ( ) Student ( ) Other: _____

Employer Name: _____ City: _____

Emergency Contact Name: _____ Phone**: _____** Relationship to client**: _____**

Treatment:

Do we have your consent to contact your primary care physician regarding your counseling sessions?

( ) Yes ( ) No ( ) I choose to decline If yes, please list the complete physician's name/information below.

Primary Care Physician (M.D.) _____ Clinic Name: _____

Address: _____ City: _____ State: _____

Phone: ( ) _____ -- _____

Do you have a psychiatrist? ( ) Yes ( ) No

If yes, would you give us consent to contact your psychiatrist regarding your counseling sessions? ( ) Yes ( ) No

Psychiatrist Name: _____ Clinic name:_____

Phone: (_____) _____--_____ Address: _____

City: _____ State: _____

Have you worked or are you currently working with any other mental health professionals?

( ) Yes ( ) No ( ) I decline If yes, please list the complete mental health professional's info below.

Professional's Name: _____ Clinic Name: _____

Phone: (_____) _____--_____ Fax: (_____) _____--_____

Address: _____ City: _____ State: _____