

Patti Ashley, Ph.D., LPC

Psychotherapy and Parent Coaching

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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 (____) _____

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 _____