Midwest
Counseling & Diagnostic Center, Inc.

# Registration Information

**Name**: _____

**DOB**: _____

**Address**:

_____

_____

**Gender**: _____

**Referred by**: _____

**Phone**: _____

▢ Permission to leave voicemail

▢ Permission to text

**Email**: _____

▢ Permission to use email

(please see Services Contract for details)

**Relationship Status**:

▢ Single / ▢ Divorced / ▢ Married /

▢ Partnered / ▢ Dating / ▢ Other

**Employment**:

▢ FT / ▢ PT / ▢ Student / ▢ Other

**Preferred Language**: _____

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**Would you like to sign a release of information for any of the following people to be involved in your treatment?**

Primary Care Physician - ▢ Accept / ▢ Decline / ▢ NA

Psychiatrist - ▢ Accept / ▢ Decline / ▢ NA

Other Treatment Providers - ▢ Accept / ▢ Decline / ▢ NA

Family - ▢ Accept / ▢ Decline / ▢ NA

Other Supports - ▢ Accept / ▢ Decline / ▢ NA

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**Emergency Contact**

Name: _____

Relationship: _____

Phone : _____

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