



141 Discovery Dr. Suite 213 | Bozeman, MT 59718 | gocmt.org

TO BE TOLD GROUP REGISTRATION FORM

Date: _____ Referred by: _____ Therapist: _____

PERSONAL INFORMATION

Full Name: _____ Cell phone: _____

Address: _____ City: _____ State/Zip: _____

Email: _____ Date of birth: _____

Highest level of education: _____ Occupation: _____

Employer: _____ Employer phone: _____

Church home: _____ Active Moderate Inactive NA

FAMILY INFORMATION

Marital status: Single Married Separated Divorced Widowed

Spouse's name: _____ Cell phone: _____

Spouse's occupation: _____ Employer: _____

Children: Name/Age _____ / _____ Name/Age _____ / _____

Name/Age _____ / _____ Name/Age _____ / _____

Previous marriage(s): Yes No Name(s)/Duration: _____ / _____

Did anyone in your family ever experience physical, sexual or emotional abuse? If yes, please explain:

Have you ever felt that you were abused? If yes, please explain:

Was anyone in your family a substance abuser? If yes, please explain:

HEALTH INFORMATION

Your current health: Very good Average Declining

Current medical problems and/or medications: _____

Are you currently in counseling? Yes No

If yes, for how long? _____ Therapist's name: _____

Aside from the information provided above, have you previously sought counseling? Yes No

Therapist: _____ Date range: _____ to _____

Therapist: _____ Date range: _____ to _____

How satisfactory was your experience(s)? _____