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LICENSED PSYCHOLOGIST

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CLIENT INFORMATION FORM

Full Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender:_____

Current Address:_____
(Street) (City) (State) (Zip code)

Permanent Address, if applicable:_____

Marital/Partnered Status: _____If married/partnered, how long together?_____

Age of Partner?_____Gender of Partner?___Name of Partner?_____

Name(s) and Age(s) of children, if any?_____

Employer: _____ Occupation: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Personal email address_____

Race/Ethnicity:_____ Religion/Spirituality:_____

Romantic/Sexual Orientation:_____

May I email you to (re)schedule appointments? Yes□ No□

May I call you to (re)schedule appointments? (please circle preferred contact number above)

Home: Yes □ No □**Work:** Yes □ No □ **Cell:** Yes □ No □**Text OK?** Yes□ No □

May I leave a message on this number? Yes □ No □

May I leave a message with someone answering this number? Yes □ No □

What is your preferred method of contact:_____

Please list any restrictions on contact: _____

***Whom may I contact in case of an emergency*?**

Name: _____ Relationship: _____

Phone: _____ Alternate phone: _____

How did you hear about my practice? (If via internet, which site first, if you recall?)

_____

If referred by a health professional, may I thank this person, as a professional courtesy? Yes □ No □

Referred to Practice by: _____

Phone and/or Email: _____

In the space below, please briefly describe the reason(s) for seeking services:

_____

_____

_____

Have you ever had previous psychotherapy or counseling? Yes □ No □

If "yes," by whom and when? _____

Reason for treatment? _____

Are you currently taking any psychotropic medication (e.g. antidepressants, anti-anxiety, attention, sleep medications?)
Yes □ No □ *If yes, list medication(s) and current dosage(s):* _____

_____

Name of prescribing Doctor: _____Phone: _____

Please list any health problems _____
List any medication(s) and current dosage(s):

_____

Have you ever been psychiatrically hospitalized? Yes □ No □ *If so, when and where?*

_____

Have you ever made a suicide attempt or gesture? Yes □ No □ *If so, please explain:*

_____

Please use the scale below to indicate your current level of distress with the following items:

	None	**Some**	**Moderate**	**Urgent**
Feelings over a recent loss/death	0	1	2	3
Relationship with friends /family	0	1	2	3
Relationship with romantic partner	0	1	2	3
Infertility/family building concerns	0	1	2	3
Sexual concerns	0	1	2	3
Sexual orientation	0	1	2	3
Survivor of abuse	0	1	2	3
Career/academic success	0	1	2	3
Distractibility or disorganization	0	1	2	3
Racial/ethnic issues	0	1	2	3
Low self-esteem	0	1	2	3
Loneliness	0	1	2	3
Depression	0	1	2	3
Anxiety, fears or worries	0	1	2	3
Sleep problems	0	1	2	3
Eating problems	0	1	2	3
Body image concerns	0	1	2	3
Caregiving to elder or for illness	0	1	2	3
Goals/meaning	0	1	2	3
Spirituality/religion	0	1	2	3
Problems with alcohol/drugs	0	1	2	3
Losing contact with reality	0	1	2	3
Suicidal feelings/behaviors	0	1	2	3