Stacey Davis, Ph.D.
Licensed Psychologist, PY 7649

Client Information Form

Identifying Information

Client Name:_____
Address:_____City:_____State:____
Zip:_____

Phone (H):_____ (Cell):_____Ext:_____
Please circle:
May we contact you at home? Y N
May we leave a message at home? Y N
May we contact you on your cell? Y N
May we leave a message on your cell? Y N

Email address:_____
May we e-mail you to remind you of appointments? Y N

Date of Birth: _____/_____/_____ Sex: _____
Referred By:_____

Place of Employment / Occupation:
Yours:_____ Partner/
Spouse:_____

Highest grade level of education completed:_____ Degree
achieved:_____

Presenting Problem

Please describe the problems that have led you to seek treatment or evaluation.
_____
_____
_____
_____

What do you believe to be the most important factor (s) causing the problem (s)?
_____
_____
_____
_____

When did you first notice these problem(s)?:_____

Have there been any family changes (new baby, death, breakup, etc.) which may be related to these problems? _____Please explain:_____
_____
_____

Prior Therapy Experience

Have you ever been seen for counseling or therapy? Yes_____ No_____

At an outpatient (clinic, private, etc.)

Name:_____
Reason for treatment_____

Name:_____
Reason for treatment_____

As an inpatient (in a hospital, residential treatment center, etc.)

Name_____
For how long?:_____
Reason for Admission_____

Name_____
Reason for Admission_____

Have you taken standard psychological assessments, (e.g. intelligence testing or personality evaluation)? Yes _____ No _____
Name of Psychologist_____
Reason for referral:_____

Medical History

Family Doctor_____
Phone (____)_____

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Have you ever been in the hospital for medical problems? Yes_____ No _____
Year hospitalized: _____
Names of hospital _____ _____
Reason for hospitalization _____

Year hospitalized: _____
Names of hospital _____ _____
Reason for hospitalization _____

Year hospitalized: _____
Names of hospital _____ _____
Reason for hospitalization _____

Do you have any serious or chronic physical or medical conditions (diabetes, etc.)?
Yes_____ No_____ If yes, please explain?
_____

Are you presently taking any prescribed / non-prescribed medication?
Yes_____No_____, If yes Please explain?
_____
Medication _____ _____ _____
How long _____ _____ _____

Do you have any allergies? Yes _____ No _____ If yes, describe what they are and list any medication (s) you take:_____
_____

Have you been injured in any accidents or falls? Yes _____ No _____, If yes, Please describe:
Incident Age Injury
_____
_____
_____
_____

Have you suffered any complications of illnesses or accidents (high fever, convulsions, coma, etc.)? Yes_____ No _____ If yes, please describe the circumstances:_____
_____
_____
_____

Were you ever unconscious, in a coma, or had a concussion as a result of illness or injury? Yes_____ No____ If yes, please

explain:_____
_____

Do you now, or have you in the past, used alcohol or other drugs on a regular basis?
Yes ____ No ____ If yes, how often and how much?
Type of Drug (Include alcohol) _____ _____
How Often? How much in each episode?
_____ _____
_____ _____

Do you now, or have you in the past, smoked cigarette / cigars / pipes on a regular basis? Yes ___ No____ If yes, how often and how much?
_____
_____

Have you experienced difficulty with any of the following?: (Please (circle) items that are currently a problem)

Headaches	Numbness/tingling in extremities	Difficulty with hearing	Shortness of breath
Trouble swallowing	Weight gain in past year	Weight loss in past year	Preoccupation with weight
Itching of skin	Hyperactivity	Nervousness	Attention/Concentration problems
Chronic fatigue/ weakness	Sudden behavior changes	Impulsivity (acting without thinking)	Physical assault/abuse
Anxiety/Panic episodes	Problems with sexual behavior	Family/Relationship difficulties	Unusual experiences
Suicide attempts	Problems with the law	Problems maintaining balance	Seizures
Fainting or black out spells	Difficulty with vision	High blood pressure	Diarrhea, chronic
Loss of appetite	Eating problems	Skin rash	Crying spells
Mood spells	Ringing in ears	Problems thinking clearly	Sudden personality changes
Depression/Anxiety	Sleeping problems	Financial problems	Occupational problems
Learning Problems	Social/Relationships problems	Disturbing thoughts	Suicidal thoughts

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Birth Information

Were there any physical or emotional difficulties during your mother's pregnancy with you? Yes_____ No _____
If yes, please describe:_____
_____
_____

Were you born premature? Yes _____ No _____
If yes, please give the number of weeks early: _____
Were there any immediate complication following delivery with you?
Yes _____ No _____
If yes, please describe:_____
_____

Pregnancy Information (Biological Females Only)
Were there any physical or emotional difficulties during pregnancy with your children?
Yes_____ No _____
If yes, please describe:_____
_____

Were any of your children premature? Yes _____ No _____
If yes, please give the number of weeks early: _____
Were there any of the following complication? Mother taking medication or drugs (specify):_____
Long labor_____Forceps delivery_____Breech birth _____ Eclampsia_____ Caesarean Section_____ other_____
Were there any immediate complication following delivery of your children?
Yes _____ No _____
If yes, please describe:_____
_____

Number of pregnancies _____ Number of miscarriages_____
Weight of largest child at birth _____

Biological Family Health Information

Has anyone in the family (including grandparent) been treated for a mental health problem? Yes_____ No _____
If yes, please explain:_____
_____
_____

List individuals that live in your home:_____

Family History

Are your parents currently married? _____ Yes _____ No
If not married how old were you when they separated? _____ Divorced? _____
Please indicate if parent(s) has remarried:_____
_____

Do you have siblings? ____ Yes _____ No
Please list ages and gender of full siblings:_____
_____

Please list ages and gender of half siblings:_____
_____

Please indicate if anyone from your immediate family (mother, father, siblings) is deceased and cause of death_____
_____

Does/Did anyone in your family (grandparent, parent, sibling, child) have cancer, drinking problems, allergies or asthma, strokes, or convulsions/epilepsy?
If yes please explain:_____
_____
_____
_____
_____

Has anyone in your family suffered from a nervous breakdown, suicide attempt, or completed a suicide?
If yes please explain:_____
_____
_____
_____
_____

Relationship History

Present marital/relationship status (check all that apply)
Single _____ Married/Commitment Ceremony _____ Live In Relationship _____
Divorced/Separated _____ Widowed _____

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If you are in a long-long term dating relationship please list months dating: _____
If married/live-in relationship:
Spouses name:_____Date of birth: ____/____/____
Date of current marriage/commitment ceremony: ____/____/____
When did you begin living together? _____
When did you begin dating?_____

Previous marriages/civil commitment/live-in relationships:
Date of Ceremony/ Began Living Together
_____ _____ _____ _____

Academic/Work

If currently a student please list year in school as well as major/ specialization:_____
Anticipated graduation for current degree:_____

Present job title / job description and organization:
_____
_____

Do you have problems performing your school work/job?
Yes___ No___
If yes please explain:_____
_____
Do you have problematic relationships with people on the job/at school?
Yes____ No ____
If yes, please explain:
_____
_____

How many jobs have you held within the past five years?_____
Reason for changes in job?_____
_____

I understand that this information will be used in my evaluation and will be included in my records.
Signed_____(Client)
Date_____

Re-Disclosure: Persons, agencies, or institutions to whom this information is disclosed are prohibited by state / federal law from re-disclosure without the specific written consent of the person to whom it pertains. A general authorization for release of medical information is NOT sufficient for this purpose.

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