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(510)559-8240

Licensed Psychologist PSY 14361

CONFIDENTIAL INFORMATION FORM

Name_____ Date_____

Social security number_____Age_____Birthdate_____

Address:_____
No. and Street City State Zip

Email address (optional):_____

Home phone: ( )_____May leave messages on home phone:____yes____no

Work phone: ( )_____May leave messages on work phone:_____yes____no

Cell phone: ( )_____May leave messages on cell phone:_____yes____no

Occupation:_____ Work days/hours:_____

____Married ____Living Together ____Separated ____Divorced ____Single

Partner name_____ Occupation_____How long together_____

If separated or divorced, for how long? _____

Names, ages, and birthdates of any children: _____

Who is living in your household at present?_____

Emergency contact name:_____ Home #_____ Cell #_____

Physician name_____ Phone # _____

Please list below any medication you are currently taking:

Medication/dose Reason for taking it Prescribing doctor

_____

_____

_____

_____

Client Name:_____ Date:_____

Please list any significant medical problems.

_____

_____

Please list any hospitalizations with dates and reasons.

_____

_____

Please list any previous psychotherapy with name of therapist, reason for treatment, dates and whether it was helpful.

_____

_____

Please describe what you'd like to achieve from therapy.

_____

_____

_____

How long has this issue been a problem for you?

_____

What have you done to try and address this issue so far?

_____

_____

_____

Please add anything else you want me to know.

_____

_____

_____

_____

_____