insight
PSYCHOLOGICAL SERVICES
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CLIENT INFORMATION FORM

Client Full Name: _____ Social Security #:_____

Date of Birth:_____/_____/_____ Age: _____ Gender:_____

Home Address:_____ Apt:_____

City:_____ State:_____ Zip:_____

Phone number:_(_____)_____ □Home □Cell Safe to Leave Message? □Yes □No

Phone number:_(_____)_____ □Home □Cell Safe to Leave Message? □Yes □No

E-mail address:_____ Okay to E-mail? □

Emergency Contact - If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Relationship to you:_____

Address: _____ Phone: _(_____)_____

_____ E-mail:_____

Medical Information

Current Medications:

Name of Medication	Dose	What is this medication for?

(please use back side to list additional medications, if needed)

If you are currently working with a psychiatrist and/or primary care physician who is prescribing medications to you for psychological reasons, please fill out the following information (if known):

Doctor's Name:_____ Practice/Company Name:_____

Address: _____ Phone: _(_____)_____

_____ Fax: _(_____)_____

E-mail:_____

Please note, your doctor(s) will not be contacted without your approval via a signed Consent to Release Information Form, which can be found at http://insightpsychologicalservices.org/forms/

Have you ever been hospitalized for psychiatric/psychological reasons? □Yes □No
If yes, please use the space below to indicate what the specific reason for hospitalization was, where you were hospitalized, and when. You may also choose to speak directly with us on this matter if you wish.

What other medical information would you like to share with us? (e.g., hospitalizations, surgeries, past medications, past/present diagnoses, etc.)

Treatment Information

Please tell us a little bit about what brings you in to see us for therapy. What are your goals for therapy? What would you like to get out of it?

Have you ever been in therapy before? □Yes □No
If yes, please fill out the following information (if known):

Dates Seen	Name of Therapist/Psychologist	Reason for Therapy
___/___ to ___/___	_____	_____
___/___ to ___/___	_____	_____
___/___ to ___/___	_____	_____

(please use back side to list additional therapists/psychologists, if needed)

If you have been to therapy before, what did you find most helpful?

Please use the space below to tell us anything else that you think would be important for us to know prior to beginning therapy: