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Licensed Psychologist

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Client Information Sheet

Client's Name: _____ Date: _____

Name of Guardian (if Minor): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ / _____ Work Phone: _____/ _____

☐ Please do not call me at home. ☐ Please do not call me at work.

Mobile Phone: _____/_____ Email Address: _____

☐ Please do not call me on my mobile phone. ☐ Ok to text. ☐ Please do not use my Email Address.

Client's Birth Date: _____ Years of Education: _____

School (current): _____ Occupation : _____

Other people living in Client's household:

Name:	Birth Date:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Client's Marital Status: ☐ Single ☐ Married ☐ Separated/Divorced (Single)
☐ Divorced/Widowed (Remarried) ☐ Widowed ☐ Other _____

Billing Information:

☐ I will pay for each session at the day of the service.

☐ Please send bills to this address only: _____

☐ Please send bills directly to my home address (listed above).

☐ Please also bill insurance (please provide necessary forms, copy of insurance card, and obtain initial authorization).

Name of Policy Holder: _____ **Relationship to Insured**: _____

Policy Holder's DOB: _____/_____/_____ Policy Holder's SSN: __ _____

Policy Holder's Home Address: Check ☐ if same as above; Or _____

_____

Insurance Carrier's Name: _____ **Policy ID Number**: _____

☐ I have received a copy of the **Colorado Notice Form.** _____ **(signature/date)**

☐ I have received a copy of the **Services Agreement** and signed it. _____ (**signature/date**)

Have you ever been in therapy before? If yes, who did you see and when were you seen? What was the outcome?

_____

List any medications you have ever taken on a regular basis, including doses and dates.

_____
_____
_____

MEDICAL HISTORY:

Name and address of your (or the minor client's) primary care physician:

_____
_____
_____

Date of most recent physical exam _____

What were the results of the exam? _____

_____

Please tell me about any major illnesses and/or operations you (or the minor client) have had. _____

_____
_____

Please tell me about any physical concerns you (or the minor client) are having at present. _____

_____

On average, how many hours of sleep do you get daily? _____ Difficulty falling asleep at night? ____ Yes ____ No

Any weight changes over 10 pounds in the past year? _____ Yes _____ No

Describe your appetite: _____

_____

Do you regularly use alcohol? ____ Do you smoke cigarettes regularly? ____ Do you smoke marijuana regularly? ___

Have you had suicidal thoughts recently? _____ if yes, when? _____ Have you ever intentionally inflicted any harm upon yourself? _____ if yes, when? _____

FAMILY HISTORY:

What's your mother's age? ____ If deceased, how old were you when she died? _____

What's your father's age? ____ If deceased, how old were you when he died? _____

If your parents are separated or divorced, how old were you when they separated or divorced? _____

If your parents divorced, has either one remarried? _____

List any siblings. _____

Were you adopted or raised with parents other than your biological parents? _____

Briefly describe if any family members have (had) emotional/behavioral problems. _____

_____

_____

CULTURAL BACKGROUND:

What is your ethnic identity? _____

How much do you identify with your ethnic heritage? _____

What is your religious preference? _____

Are you currently active in your religion? _____

Does your family speak a different language other than English at home? _____ What language? _____

FAMILY BACKGROUND:

Please discuss any past, present, or impeding special problems in your family (i.e., deaths, divorce, relocations, injuries, illnesses, financial crisis, unemployment, legal problems, suicide, etc.) _____

Have you personally experienced significant abuse? _____

Have you personally experienced legal problems? _____

Did you experience learning problems in school? _____

In general, how happy or adjusted (1-10) were you growing up? _____

How much (1-10) is your immediate family a source of emotional support for you? _____

How much conflict in values do you currently experience with your parents? _____

Who in your family do you currently feel closest to? _____ Most distant from? _____In most conflict with? _____

SOCIAL ISSUES:

In the past, how would you rate the quality of your peer relationships? _____

Approximately how many significant intimate relationships (> than 6 months or more) have you been involved in? ___

Besides family members, approximately how many people can you really count on for emotional support? _____

ADDITIONAL INFORMATION ABOUT YOURSELF:

(optional)

By signing below, I authorize Dr. Godwin to accept assignment of benefits and to release any information necessary to process my insurance claim.

Signature _____ Date _____