

Initial Client Information Form

Today's Date: _____

Client/Minor Information:

Last Name: _____ First Name: _____ Middle Name: _____

Age: _____ Date of Birth: _____ Place of Birth: _____

Gender Identity: _____ Ethnicity: _____

Sexual identity: _____

Religious/Spiritual Identity (if any): _____

Relationship Status: _____

Name & year level in School:

Contact Information:

Address: _____

Ok to mail? No Yes

Email Address: _____

I understand that email may not be secure, but authorize use of this email for correspondence about appointments. No Yes

Cell #: _____ Work #: _____ Home #: _____

At which of these numbers can the therapist leave messages? _____

(1) Client's Guardian Information:

Name: _____ Age: _____ Date of Birth: _____

Address (if different from above): _____

Ok to mail? No Yes

Email Address: _____

I understand that email may not be secure, but authorize use of this email for correspondence about appointments. No Yes

Name/Age of any other children/adults living at this residence:

Cell #: _____ Work #: _____ Home #: _____

At which of these numbers can the therapist leave messages? _____

Nature of Employment: _____

Name/Age of Spouse or Partner (if applicable): _____

Length of Relationship: _____

(2) Client's Guardian Information:

Name: _____ Age: _____ Date of Birth: _____

Address (if different from above): _____

Ok to mail? No Yes

Email Address: _____

I understand that email may not be secure, but authorize use of this email for correspondence about appointments. No Yes

Name/Age of any other children/adults living at this residence:

Cell #: _____ Work #: _____ Home #: _____

At which of these numbers can the therapist leave messages? _____

Nature of Employment: _____

Name/Age of Spouse or Partner (if applicable): _____

Length of Relationship: _____

Reason for Visit:

Please list the reason(s) / goal(s) for this visit: _____

Please check the issues that are currently of concern to the client and/or guardian:

Abuse

Eating Issues

Procrastination

- | | | |
|--|--|---|
| <input type="checkbox"/> Alcohol or drug use | <input type="checkbox"/> Family Problems | <input type="checkbox"/> Self-esteem |
| <input type="checkbox"/> Anger management | <input type="checkbox"/> Financial Difficulties | <input type="checkbox"/> Sense of self/identity |
| <input type="checkbox"/> Anxiety, fears, nervousness | <input type="checkbox"/> Harassment | <input type="checkbox"/> Sex |
| <input type="checkbox"/> Career / job related | <input type="checkbox"/> Identity Issues | <input type="checkbox"/> Sleep Concerns |
| <input type="checkbox"/> Cultural issues | <input type="checkbox"/> Interpersonal Issues | <input type="checkbox"/> Stress or tension |
| <input type="checkbox"/> Concentration | <input type="checkbox"/> Job Search | <input type="checkbox"/> Suicidal Thoughts or Behaviors |
| <input type="checkbox"/> Depression/sadness | <input type="checkbox"/> Loss, grief, or death | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Delusions or hallucinations | <input type="checkbox"/> Medical or health related | <input type="checkbox"/> Other _____ |

Client's Medical/Mental Health History:

Describe any health problems: _____

Medications/Dosages: _____

Physician's Name and Phone #: _____

Psychiatrist's Name and Phone #: _____

Has the client ever been hospitalized for psychological reasons or drug dependency? _____

If so, please describe the date(s) and nature of the hospitalization: _____

List any previous / current psychological treatment:

Type of Service: _____ Date: _____ Provider: _____

Type of Service: _____ Date: _____ Provider: _____

Relevant Developmental History: _____

Emergency Contact:

Name and phone number of someone to contact in an emergency:

Name: _____ Phone #: _____ Relationship: _____

Private Practice of Alicia del Prado, Ph.D.
Psychologist PSY 24116

PHONE (510) 390 4147
E-MAIL adelprado@wi.edu

Name: _____ Phone #: _____ Relationship: _____