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

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

Initial Client Information Form

Today's Date: _____

Client 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: _____

Nature of Employment: _____

Name of Employer: _____

If student, year level, & name of school (include a major, if applicable):

_____

If graduate student, name of undergraduate institution:

_____

Contact Information:

Address: _____

Ok to mail? O No O Yes

Email Address: _____

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

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

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

Reason for Visit:

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

_____

_____

_____

Please check the issues that are currently of concern to you:

O Abuse
O Alcohol or drug use
O Anger management
O Anxiety, fears, nervousness
O Career / job related
O Cultural issues
O Concentration
O Depression/sadness
O Delusions or hallucinations
O Eating Issues
O Family Problems
O Financial Difficulties
O Harassment
O Identity Issues
O Interpersonal Issues
O Job Search
O Loss, grief, or death
O Medical or health related
O Procrastination
O Self-esteem
O Sense of self/identity
O Sex
O Sleep Concerns
O Stress or tension
O Suicidal Thoughts or Behaviors
O Trauma
O Other_____

Client's Medical/Mental Health History:

Describe any health problems: _____

Medications/Dosages: _____

Physician's Name and Phone #: _____

Psychiatrist's Name and Phone #: _____

Have you 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: _____

Insurance Information:

Type of Insurance: _____

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Individual Number: _____ Group Number: _____

Emergency Contact:

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

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____