

CLIENT INFORMATION FORM

Today's date _____

Name _____ Date of birth _____

Mailing address _____

Phone: Home _____ Work _____ Cell _____

If email is a good way to reach you, address: _____

Name of spouse or partner _____ How long together? _____

Children names and ages _____

Employment status: employed ___ not employed ___

If employed, where and doing what? _____

Highest level of education: ___ Some high school ___ High school grad ___ Some college
 ___ College grad ___ Graduate work ___ Graduate degree

Name of your physician _____

Current medical diagnoses _____

Symptoms of concern _____

Please list all prescribed medications you are taking: _____

Have you ever received counseling or psychotherapy before? No ___ Yes ___

If yes, when? _____

Are you currently in counseling or psychotherapy? No ___ Yes ___

If yes, with whom? _____

Have you ever been hospitalized for mental health reasons? No ___ Yes ___

If yes, when and where? _____

Person to contact in case of emergency _____

How you found out about this practice _____

What do you hope to gain here? _____

Anything else you would like me to know? _____

Please email or fax this form to:

William Collinge, Ph.D.

Email William@collinge.org

Fax 207-510-8060