

**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 mail or fax this form to:

William Collinge, Ph.D.

P.O. Box 263

Kittery Point, ME 03905

Fax 207-510-8060