LUCY T. SMITH, PHD

CLINICAL PSYCHOLOGIST

Client Information Form

Date: _____

Name: _____ Age: _____ DOB: _____

Address: _____

Street Apt City State Zip

Phone: Home _____ Is it okay to leave a message? No Yes

Cell _____ Is it okay to leave a message? No Yes

Work _____ Is it okay to leave a message? No Yes

E-mail: _____ Gender: _____ Ethnicity/Race: _____

Marital/Relationship Status: Single Married Partnered Separated Divorced Widowed Other: _____

Children (list name/age of each): _____

Who do you currently live with? _____

Religious Affiliation/Spirituality: _____

Education Information:

If not currently in school, what is your highest level of education: _____

If currently in school:

School Name: _____ Major: _____

Class: Freshman Sophomore Junior Senior 5th Year Graduate

School Status: Full-time Part-time Continuing Education

Employment Information:

Employment: Full-time Part-time # Hours/Week: _____

Occupation/Employer: _____

Other Health/Service Providers (e.g., Primary Care Physician, Psychiatrist, Therapist, Dietician, etc.):

Name: _____ Provider Role: _____ Phone: _____

Name: _____ Provider Role: _____ Phone: _____

Name: _____ Provider Role: _____ Phone: _____

Emergency Contacts:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Prior Mental Health Treatment:

Have you ever been hospitalized for a psychological or psychiatric issue? YES NO

If yes, please describe:

Have you ever received treatment for mental health or substance use concerns? YES NO

If yes, please provide dates, type of treatment, provider information, duration, and helpfulness below.

Any history of suicidal thoughts or attempts? YES NO

If yes, when?

Medical History:

When was your most recent physical exam? _____ Allergies: _____

Please list all current medications: _____

Significant medical concerns or conditions:

_____

History of head injury, seizures, or loss of consciousness?

_____

Legal History:

Have you ever been arrested or convicted of a legal violation? YES NO

If yes, please describe:

Referral Source:

Referred to Dr. Lucy Smith by: _____

May I contact your referral source to acknowledge the referral? YES NO

Reason for Visit:

What are the main reasons you are seeking treatment? Please check all that apply.

□ Sadness/Depression
□ Anxiety/Worry
□ Fear
□ Stress
□ Physical Symptoms
□ Grief/loss
□ Work/School Difficulties
□ Relationship Difficulties
□ Traumatic Experience
□ Self-acceptance
□ Other: _____

□ Hopelessness
□ Irritability
□ Anger
□ Low Self-Esteem
□ Sleep Difficulties
□ Suicidal Thoughts
□ Self-Harm
□ Thoughts of Harming Others
□ Sexual Difficulties
□ Alcohol or Substance Use
□ Worthlessness or Guilt

□ Perfectionism
□ Eating/Weight Concerns
□ Overexercise
□ Body Dissatisfaction
□ Obsessions/Compulsions
□ Panic attacks
□ Loneliness/Isolation
□ Impulsiveness
□ Identity Concerns
□ Fatigue
□ Trouble Concentrating