Sogol Philipson, LCSW
LCSW # 66853
4199 Campus Drive Ste. 550
Irvine, CA 92612

Date:

Client Information

(Couples, please fill out your own registration)

First Name _____ Last Name_____

Sex_____ Age_____ Date of Birth_____

Address: _____

City_____ State _____Zip_____

Home Phone Number_____ Cell Phone Number_____

Permission to leave a message at home? _____

Permission to leave a message on cell? _____

Permission to text confidential messages on cell? _____

Driver's License Number _____ State Issued: _____

Email Address _____

Emergency Contact _____

Relation to Client _____

Emergency Contact Phone Number _____

Marital Status How Long _____

○ Married ○ Divorced ○ Widowed ◉ Single

Employment Status

◉ Employed ○ Unemployed ○ Disability ○ Retired

Employer _____

Occupation _____

Level of Education

◉ High School Graduate ◯ Trade School ◯ Some College ◯ M. S/M. A
◯ PHD

Patient / Client Information

Current concerns:

_____

_____

_____

_____

_____

_____

Previous Psychiatrist / Therapist:

_____

_____

_____

Describe the problems for which you sought therapy in the past:

_____

_____

_____

_____

_____

Your experience with previous therapy

◯ Positive ◉ Neutral ◯ Limited ◯ Negative

Have you been hospitalized for psychiatric or substance abuse problems?

○ Yes ⊙ No

If Yes, please list:

_____

_____

_____

_____

Facility _____

Reason:

_____

_____

_____

_____

Do you have any history of suicide attempts or history of assault?

○ Yes ⊙ No

If Yes, please list:

_____

_____

_____

_____

Medications

Please list all current drugs/medications, including over-the-counter.

_____

_____

Please list any previous Psychiatric drugs/medications:

_____

_____

_____

_____

Physical Health Status

Do you have any existing medical problems or current symptoms of concern to you? If so, please describe below

_____

_____

_____

_____

Please indicate any major illnesses, accidents, and/or hospitalizations within the last 5 years:

_____

_____

Do you smoke? Per Day: _____ Do you drink Alcohol? Per Week_____

◯ Yes ⦿ Yes

⦿ No ◯ No

Do you engage in any other substance/drug use? _____ If yes, please explain:

_____

_____

_____

_____

How would you rate your current sleeping habits?

◯ Poor ⦿ Unsatisfactory ◯ Satisfactory ◯ Good ◯ Very Good

Please list any specific sleep problems you are currently experiencing:

_____

_____

_____

How many times per week do you generally exercise?

_____

_____

What types of exercise do you participate in?

_____

_____

_____

Please list any difficulties you experience with your appetite or eating problems:

_____

_____

_____

Are you currently experiencing overwhelming sadness, grief or depression?

◉ Yes ◯ No

If yes, for approximately how long?

_____

_____

Are you currently experiencing anxiety, panics attacks or have any phobias?

◯ Yes ◉ No

If yes, when did you begin experiencing this?

_____

_____

Are you currently experiencing any chronic pain?

◯ Yes ◉ No

If Yes, please describe:

_____

_____

_____

_____

_____

Family Background:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

Check the boxes that apply

Alcohol/Substance Abuse Anxiety Depression
Domestic Violence Eating Disorders Obesity
Obsessive Compulsive Behavior Schizophrenia
Suicide Attempts

Family Member _____

Alcohol/Substance Abuse Anxiety Depression
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Family Member _____

Do you consider yourself to be spiritual or religious?

◉ Yes ◯ No

If yes, describe your faith or belief

_____

_____

_____

Please describe your family relationships:

_____

_____

_____

Any history of family physical or sexual abuse:

_____

_____

_____

Social/Occupational/Family Functioning:

Do you have a social network? _____ Do you have close friends? _____

How often do you make contact with friends?

_____

Are you currently in a romantic relationship?

◉ No ○ Yes, its Generally positive ○ Yes, it is Neutral

○ Yes, it is Problematic

Are you able to talk to others about the concerns that bring you into therapy?

◉ Yes ○ No

What is your living situation?

_____

How do you feel about work?

◉ N/A ○ Unhappy ○ Pleased ○ Mixed

○ Mostly Satisfied

How do you feel about school?

◉ N/A ○ Unhappy ○ Pleased ○ Mixed

○ Mostly Satisfied

Any major dissatisfaction with:

◉ N/A ○ Work School ○ Marriage ○ Family Friends

If Yes, Please Explain:

_____

_____

Please describe any hobbies or recreational or enjoyable activities:

_____

_____

_____

_____

Other Information you want me to know about you: