Fulton Psychological Group

CLIENT INFORMATION

Name:_____ Date:_____

Home Address:_____
Street City Zip Code

Home Phone #:_____ Work Phone #:_____

Cell Phone #:_____ e-mail:_____

Birth Date:_____ Occupation:_____

Employer:_____

Marital Status:_____ If married spouse's name:_____

Education/Degree(s) completed:_____

Previous Therapy:_____
Therapist's Name Period of Time Therapy Issue(s)

Physician:_____ Phone #:_____

Please describe your living arrangements:

_____ _____
Name Age Relationship Name Age Relationship

_____ _____
Name Age Relationship Name Age Relationship

In case of emergency, notify:_____ Phone #:_____

Initial here if you are forwarding invoices to your insurance company for reimbursement: _____
If so, please provide an e-mail address to receive invoices: _____.

Who referred you to my practice? _____

It is customary to thank the referring person. **Your signature below gives me permission to contact and thank this person**. No other information will be disclosed.

Signature:_____ Date:_____

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Why are you seeking therapy at this time? _____

_____

_____

Check any symptoms you have exhibited in the past six months:

___ Sadness/Crying Spells
___ Socially Isolated
___ Appetite/Weight Loss
___ Insomnia
___ Excessive Sleep
___ Giving Up Easily
___ Difficulty Having Fun
___ Excessive Anger/Hostility
___ Suicidal Thoughts/Statements
___ Sexual Dysfunction
___ Lethargy
___ Long Periods of Elation
___ Nervousness/Jittery
___ Irritable/Temper Outbursts
___ Persistent Thoughts
___ Mood Swings
___ Excessive Worrying
___ Fidgety
___ Excessive Nightmares
___ Self Mutilation
___ Overeating/binging
___ Panic Attacks
___ Intrusive Thoughts
___ Excessive Fears
___ Other (please describe): _____

List and describe any history of emotional disorder(s) in your biological family:

_____

_____

List and describe any significant life events (e.g. divorce, death in family, etc.):

_____

_____

List and describe any current or historical physical concerns:

_____

_____

List and describe any drug and/or alcohol use: _____

_____

List any medication(s) and dosage you are currently prescribed: _____

_____

What are your strengths and hobbies? _____

_____