



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: _____

Why are you seeking therapy at this time? _____

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

- | | |
|---|---|
| <input type="checkbox"/> Sadness/Crying Spells | <input type="checkbox"/> Nervousness/Jittery |
| <input type="checkbox"/> Socially Isolated | <input type="checkbox"/> Irritable/Temper Outbursts |
| <input type="checkbox"/> Appetite/Weight Loss | <input type="checkbox"/> Persistent Thoughts |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Excessive Sleep | <input type="checkbox"/> Excessive Worrying |
| <input type="checkbox"/> Giving Up Easily | <input type="checkbox"/> Fidgety |
| <input type="checkbox"/> Difficulty Having Fun | <input type="checkbox"/> Excessive Nightmares |
| <input type="checkbox"/> Excessive Anger/Hostility | <input type="checkbox"/> Self Mutilation |
| <input type="checkbox"/> Suicidal Thoughts/Statements | <input type="checkbox"/> Overeating/binging |
| <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Lethargy | <input type="checkbox"/> Intrusive Thoughts |
| <input type="checkbox"/> Long Periods of Elation | <input type="checkbox"/> Excessive Fears |
| <input type="checkbox"/> 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? _____
