

Beverly A. Brosky, Psy.D., PLLC
Licensed Psychologist

Client Information Form

Date: _____

Demographic Information

Full Name: _____ SSN # _____

Address: _____

Home Phone: _____ Okay to leave message Y ___ N ___

Work Phone: _____ Okay to leave message Y ___ N ___

Cell Phone: _____ Okay to leave message Y ___ N ___

How do you prefer I contact you? Home ___ Work ___ Cell ___

Any Call Restrictions on any Phone: _____

Age: _____ Birth Date: _____ Gender: Male _____ Female _____

Marital Status: Never Married: ___ Married ___ Partnered ___ Divorced ___ Separated ___ Widowed ___

Occupation: _____ Employer: _____

Past Education: _____ Currently in School/Where? _____

Emergency Contact: _____ Phone _____

Relationship to You _____

Referral Source: _____ Permission to thank person Y ___ N ___

CHIEF CONCERN

Please describe the main difficulty that brought you to see me:

Dr. Beverly A. Brosky, Psy. D. , PLLC

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MEDICAL INFORMATION

Primary Care Physician: _____ Phone _____

Date of Last Physical Exam _____ Findings from that Exam _____

Current, ongoing medical conditions (e.g., diabetes, hypertension, heart problems, asthma, head trauma, cancer, etc.)

MEDICATION

Please list current medications, dosage, what for, and prescribing physician:

Have you been previously prescribed psychiatric medication (antidepressants, or others)?

Yes _____ No _____

If yes, what medication, dosage, dates began/ended?

Previous Psychotherapy/ Drug/Alcohol Treatment, Mental Health Hospitalization

Have you had previous psychotherapy/counseling, drug or alcohol treatment? Yes _____ No _____

If yes, from whom, dates, reason (s) for therapy or treatment

Have you ever been hospitalized for psychiatric reasons? Yes _____ No _____

If yes, what hospital, date began/ended, precipitating event? _____

Family History of Mental Health Problems or Chemical Dependency:

Signature: _____ **Date** _____