dr JUDY®
PSYCHOLOGICAL HEALING CENTER

New Client Information Form

Personal

Name: ____ DOB: ______/_______/______

First M.I. Last MM / DD / YYYY

Home Address:____

Street Apt. City/State Zip

Client's Gender (circle one): Male Female

Marital Status (circle one): Single Married *Other: ______________________________

*Other includes Divorced, Widowed & Domestic Partnerships

School or Work Status (circle **only** one): F/T Student P/TStudent Employed Not Employed

Home Phone: (______) _______________Cell Phone: (_______) _______________

Alternate Confidential Number: (_______) _______________

Email: ____

Nickname: ____

How did you hear about us? ____

Medical Problems

Do you have any medical conditions? (If yes, please describe)

____

List any prescription medications you are currently taking:

____

Name of prescribing physician ____

Physician Phone: (_______) _______________

Primary Insurance Information

Insurance Provider: ____

Social Security #: _________/_________/_________

Insurance Company: ____

Insurance Company Phone #: (_______) _______________

Subscriber's Name (if different): ______________________________________

Subscriber's Date of Birth: _____ /______ /______

Relationship to Client: ____

Subscriber's Employer: ____

Subscriber's Insurance ID#:____

Subscriber's Group Policy/ID ____

Subscriber's Phone # (if different): (________)_____________________________

Subscriber's Address (if different): ____

Street Apt. City/State Zip

Employer

Employer: ____

Phone: (______)____________________

Address: ____

Street Apt. City/State Zip

Emergency

In Case of Emergency Notify: ______________________________

Phone: (______)____________________

Relationship:______________________________________

Primary Care Physician:______________________________

Phone: (______)____________________

Psychiatrist: ______________________________________

Phone: (______)____________________

Mental Health Information (All areas marked with a * MUST be completed)

Reason(s) for seeking counseling (circle all that apply):

ADD/ADHD	Depression	Panic Attacks	Compulsions
Anger	Employment	Phobias	Medically Related
Anxiety	Family	Self Harm	Substance Abuse
Children	Gender	Sexuality	Couple/Marital
Chronic Pain	Grief/Bereavement	Stress	Obsessions

Other Issues (please specify):

____

How long ago did you first experience the issue you are seeking counseling for? __________

Periods of prior counseling and/or psychiatric hospitalizations (*if applicable*):

____

Prescribed Mental Health Medications:

Name: ____________________ Dosage: ____________________

Frequency: ____________________

Name: ____________________ Dosage: ____________________

Frequency: ____________________

Other Health Information

Do you smoke or use tobacco products? (circle one): Yes No

How much per day?: ________ Per Week? ________

Do you drink alcohol regularly? (circle one): Yes No

How many drinks per day?: ________ Per Week? ________

Does the Client use drugs? (circle one): Yes No

How many times per day?: ________ Per Week? ________

PSYCHOLOGICAL HEALING CENTER

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