Deb Lang, PsyD – Licensed Psychologist – Creating Choices PC

CONFIDENTIAL CLIENT INFORMATION FORM

Full Name: _____ Today's Date: _____

Nickname/Preferred Name: _____ Age: ____ Date of Birth: _____

Complete Address (including zip):
_____
_____

Preferred Contact Phone #'s:
_____/_____/_____
(Home) (Work) (Cell)
Do I have your permission to leave a message at these numbers? _____

Email Address: _____

Person to contact in case of emergency_____ Phone #_____

Your Occupation: _____ Place of Employment:_____

Who suggested that you contact me? _____
(e.g.,- a friend, physician, phonebook)
May I briefly contact this person or agency to acknowledge the referral? ___ Yes ___ No
If yes, your signature_____

Name of your health care provider(s) and date of last visit:
_____

List any health problems for which you are currently receiving treatment.
_____
_____

Please list any medications which you are now taking and the condition for which you take them:
_____
_____

*****Please complete both sides of these sheets******

Please describe any other significant health problems that you have had in the past:_____

_____

Please list the current members of your household:

Name	Age	Relationship	Occupation

Have you been in counseling or therapy before or received any type of psychiatric help? ___ Yes ___ No Hospitalized? ____ Yes ____ No
If you have, please briefly state reason, year and the name of the professional seen:

_____

_____

Briefly describe your reasons for seeking counseling:_____

_____

_____

What are your goals for counseling (what would you like to accomplish or to be different in your life?

_____

_____

Please add any additional information which you feel may be helpful_____

_____

_____

Please circle any of the following problems that pertain to you:

Abandonment	Elevated Mood	Panic Attacks
Abuse	Fatigue	Paranoia
Aggression	Finances	Restricted Eating
Anger	Flashbacks	Sadness
Anxiety/Anxiousness	Grief/Loss	Self-harming behaviors
Binging/purging	Guilt	Harsh/critical/low self-compassion
Chronic pain	Hallucinations	Sleep- falling asleep
Concentration	Hopelessness	Sleep – staying asleep
Compulsive/emotional Eating	Hyperactivity	Self-control
Decreased energy	Impulsivity	Sexual Difficulties
Decreased enjoyment	Inattention	Physical health
Depression	Irritability	Suicidal Ideation – current/past
Dissociation	Isolation	Substance abuse
Divorce/Separation	Legal	Suspiciousness
Eating Issues	Life Change	Trauma - current
Educational difficulties	Memories	Trauma- past
Body Image	Nightmares	Weight loss
Compulsions	Obsessions	Withdrawing/Isolating
Weight Gain	Occupational	Worried

Other_____

Please complete the insurance information on the following page if you would like your bills submitted to your insurance company.

Insurance Information – Please bring a copy of your insurance card-

Insurance Company:_____

Subscriber ID#_____ Group #_____

If the subscriber is someone other than yourself, please provide the following information:

Subscriber's full name:_____

Address:_____

_____

Please note - I am an in-network provider with Allegiance, Blue Cross, Cigna (not EAP), First Choice Health, Medicare, MHNet, and Pacific Source. If you have other insurance, please call them, prior to our first session, to determine whether you require preauthorization.

Thank you for completing this form.