Lisa Gabardi, Ph.D., LLC

Licensed Psychologist

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CLIENT INFORMATION

Please fill out the following to the best of your knowledge. **Date:** ________________________

Client Name: __________________________________ **Preferred Pronoun** (circle): he/him/his, she/her/hers, they/them/theirs

Address: _____________________________________ **Birthdate:** ___________________________
_____________________________________ **Age:** ___________________________

Phone: (H)____________________ **(W)**____________________ **(Cell)**____________________

Alternative Communication Channels

- Yes, Direct Postal Mail to the Above Address
- No, Please mail me at: ____

I give permission to be called at (please circle all that apply) **(H) (W) (Cell)**
You may leave a message at (please circle all that apply) **(H) (W) (Cell)**
You may contact me via **email at:** ____
Restrictions on messages and/or Special Instructions regarding contacting you: ________________________
____

Would you like to be added to my newsletter with the above email address? _______Yes _______No

<u>Emergency Contact</u>

Name of person to contact in case of emergency: ____
Address: ____ *Phone:* __________________________
Relationship to yourself/client: ____

<u>Insurance Information</u>

Name of Policy Holder: ________________________________ **Relationship to You:** _____________
Policy Holder Birthdate: ___________________ **Policy Holder Social Security #:** ___________________
Insurance Plan: ____
Insurance Billing Address: ____
____
Policy Number: ______________________________ **Group Number:** ___________________________

<u>Personal</u>

Ethnicity: ______________________ **Relationship Status:** ___________________
Number of Years of Education Completed (12= Completed High School)**:** _________________________
Occupation/ Grade in School: ____
Employer/School Name & Address: ____
____

Please list all individuals that you consider members of your immediate family (e.g. significant other, spouse, children, siblings, parents, etc.)**:**

Name	*Relationship*	*Age*	*Location*

Please continue on reverse side if you need more space for family members

Who referred you to this office? ____

Name:_______________________________________ Client information continued

Health

Primary Care Physician: ____

Last Physical Exam / Visit to the Doctor: ______________________________

Current Medications: ____

Allergies (including to medications):____

Current Health Concerns: ____

____

Past Health Problems/ Accidents/ Hospitalizations:____

____

Prior Use of Mental Health Services (Names of providers and dates seen): ___________________________

____

Please check all of the following which currently apply to you:

_____ I have no problems or concerns
_____ Abuse
_____ Anxiety or Fears
_____ Appetite/Eating disturbances
_____ Anger
_____ Alcohol/Drugs (myself)
_____ Alcohol/Drugs (my family)
_____ Attention, Concentration, Distractibility
_____ Bizarre thoughts or behaviors
_____ Compulsive behaviors
_____ Depression
_____ Family Problems(Current or Historical)
_____ Fatigue
_____ Financial Concerns, Impulsive Spending
_____ Grief/Mourning/Death/Loss/Divorce
_____ Health concerns
_____ Impulsive/ reckless behaviors
_____ Legal involvement or concerns
_____ Obsessions/Compulsions/Repetitive
_____ Parenting/Children
_____ Perfectionism
_____ Relationship concerns
_____ Self-Esteem/Poor Self-Care
_____ Shyness/Sensitivity
_____ Sexual concerns (identity, desire, abuse,etc.)
_____ Sleep disturbance
_____ Suicidal thoughts
_____ Violent thoughts or actions
_____ Withdrawal/ social isolation
_____ Work/Employment related problems
_____ Other concern:________________________
_____ Other concern:________________________

Briefly describe what brings you to seek psychotherapy now?

____

____

Initial Treatment Goals

What do you want to be different (please be specific) as a result of seeking psychotherapy?

____

____

____ ____________________________________

Signature of Client or Personal Representative Date

____ ____________________________________

Printed Name of Client or Personal Representative Relationship to Client

____

Description of Personal Representative's Authority

This information will be maintained as part of your confidential file with Dr. Gabardi.

Alternative Communication Channels _____ *Accepted*
_____ *Refused* Reason(s):___________________________________

____

Signature-Dr. Gabardi, Privacy Officer	Date