Brooke A. Dean, Ph.D.
Licensed Clinical Psychologist

CLIENT INFORMATION FORM

Name:_____ **Date:**_____

Age:_____ **Date of Birth:**_____ **Pronouns:**_____

_____

Street Address **City/State** **Zip Code**

_____ _____

Home/Mobile Phone **Email Address**

_____ _____

Employer **Occupation**

_____

Work #

EMERGENCY CONTACT INFORMATION

Name:_____

Relationship to you:_____

_____

Street Address **City/State** **Zip Code**

_____

Home/Mobile Number

MEDICAL/FAMILY HISTORY INFORMATION

Physician's Name:_____ **Phone #:**_____

_____

Physician's Address **City/State** **Zip Code**

_____

Significant Medical Conditions (past or present)

Are you currently taking any medications? □ Yes □ No

If yes, please list:

Medication	Dosage	Frequency	Start Date	End Date	Physician	Phone

Date of Last Physical Exam:_____

Family Members	Relationship to you	Age	Education/Occupation

Has any family member had a psychiatric disorder? If yes, who/what and outpatient therapy?
□ Yes □ No

_____

_____

Has any family member used psychotropic medications? If yes, who/what/why?

□ Yes □ No

_____

_____

Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder? If yes, who/why?

□ Yes □ No

_____

_____

Additional Information (e.g., types of relationships with family, significant events in family, etc):

_____

_____

To what extent does your cultural identity (ethnicity, nationality, etc) play an important role in your life?

_____

_____

To what extent does your religious or spiritual preference play an important role in your life?

_____

_____

Relationship Status:_____

For the following behavioral chart, please use this key to reflect your personal experiences:

None	**This symptom is not present at this time**
Mild	**Impacts quality of life, but no significant impairment of day-to-day functioning**
Moderate	**Significant impact on quality of life and/or day-to-day functioning**
Severe	**Profound impact on quality of life and/ro day-to-day functioning**

Symptom	**None**	**Mild**	**Moderate**	**Severe**	**N/A**
Depressed feelings	□	□	□	□	□
Feeling hopeless	□	□	□	□	□
Sleep problems	□	□	□	□	□
Fatigue/low energy	□	□	□	□	□
Poor concentration	□	□	□	□	□
Indecisive	□	□	□	□	□
Feeling worthless	□	□	□	□	□
Feeling overwhelmed	□	□	□	□	□
Irritability/anger	□	□	□	□	□
Agitated/restless	□	□	□	□	□
Somatic complaints	□	□	□	□	□
Impulsive behavior	□	□	□	□	□
Self criticism	□	□	□	□	□
Guilt/shame	□	□	□	□	□
Mood: highs/lows	□	□	□	□	□
Feeling high without drugs	□	□	□	□	□
Overly energetic	□	□	□	□	□
Lying/stealing	□	□	□	□	□

Symptom	None	Mild	Moderate	Severe	N/A
Aggressive behavior	□	□	□	□	□
Violent thoughts	□	□	□	□	□
Thoughts about harming others	□	□	□	□	□
Thoughts about ending my life	□	□	□	□	□
Suicidal gesture/attempt	□	□	□	□	□
Self-mutilation	□	□	□	□	□
Feelings of grief/loss	□	□	□	□	□
Death of someone close	□	□	□	□	□
Anxiety	□	□	□	□	□
Panicky feelings	□	□	□	□	□
Fears or phobias	□	□	□	□	□
Obsessive thoughts	□	□	□	□	□
Compulsive behaviors	□	□	□	□	□
Health problems	□	□	□	□	□
Appetite disturbance	□	□	□	□	□
Weight gain/loss	□	□	□	□	□
Body image issues	□	□	□	□	□
Restricted food intake	□	□	□	□	□
Using laxatives	□	□	□	□	□
Binging/purging	□	□	□	□	□
Alcohol use	□	□	□	□	□
Drug use	□	□	□	□	□
Physical assault/abuse	□	□	□	□	□
Sexual assault/abuse	□	□	□	□	□
Verbal assault/abuse	□	□	□	□	□

Symptom	None	Mild	Moderate	Severe	N/A
Financial problems	□	□	□	□	□
Gambling problems	□	□	□	□	□
Academic concerns	□	□	□	□	□
Career concerns	□	□	□	□	□
Family problems	□	□	□	□	□
Alcohol/drug concerns	□	□	□	□	□
Relationship problems	□	□	□	□	□
Social isolation	□	□	□	□	□
Withdrawing from others	□	□	□	□	□
Sexual concern/question	□	□	□	□	□