Client Information Form

Name:_____ Referred by:_____
Date of 1st visit:_____ Your Physician:_____
Date of Birth:_____ Your Psychiatrist:_____
Address:_____ City, State, Zip:_____
Occupation:_____ Employer:_____
Phone: (H/C)_____ (W)_____
Email Address:_____
Person to contact in case of emergency: _____Phone:_____

Initial Evaluation Questionnaire

Please describe in the space below your reason(s) for seeking help at this time:

Please circle any of the following problems which may be of concern:

Nervousness/Anxiety	Shyness	Loss of loved one	Alcohol/Drug Use
Sleep difficulties	Legal issues	Low energy	Loneliness
Prob. With Temper	Eating issues	Low Self Esteem	Feeling Moody
Depression	Sexual Issues	Stress	Nightmares
Premenstrual tension	Appetite Probs.	Apathy	Boredom
Feelings of Emptiness	Relationship Probs.	Panic Symptoms	Fears
Difficulty with Children	Suicidal Thoughts	Work Issues	Finances
Probs. Making Decisions	Health Problems	Marital Problems	Stomach Probs.
Probs. W/ Concentration	Compulsive Behav.	Marital Infidelity	Assertiveness
Obsessive Thoughts	Disorganization	Inattention	Distractibility

Have you ever had previous contact with a mental health professional? Yes___ No___
If yes, please list the year, provider name, and reason for treatment:

Are you concerned about your own use of alcohol or any other drugs? Yes___ No___
Are you concerned about the use of alcohol/drugs by somebody else? Yes___ No___
Do you smoke cigarettes? Yes___ No___
Have you ever had an unwanted sexual experience? Yes___ No___
Have you ever had a head injury? Yes___ No___
Have you ever experienced a violent or otherwise traumatic event? Yes___ No___
Has a family member ever been treated for emotional difficulties? Yes___ No___

Has a family member ever suffered from any of the following problems:
Anxiety/Panic___ Alcohol/Drug Abuse___ Depression___ Suicidal Impulses___
Violent Tendencies___ Obesity___ Marital Problems___ Child Abuse___

If you endorsed any of the items about your family, please explain in the space below:

Medical History
Date of last physical exam by physician:
Current medications:

Serious childhood illnesses (e.g., polio, rheumatic, high fevers, etc.):

Serious current medical illnesses or allergies:

Past serious injuries (e.g., losing consciousness, broken bones, etc.):

Release of Information and Patient Privacy

Please read and sign the following release of information agreement. This release only applies to the parties listed in the statement. Information released to additional parties would require additional client consent.

I, (Print Name),_____, agree to allow Dr. Jacob Pickard to communicate about my case and condition with my insurance company for billing purposes and to my Primary Care Physician and Psychiatrist in order to provide continuity of care among my health providers. In addition, I am aware of and have reviewed the Notice of Privacy Practices.

_____ _____
Patient Signature *Date*