

Birchtree Psychology
30 Sever Street
Worcester, MA 01609

Client Information Form

Today's date: _____

Note: If you have been a patient here before, please fill in only the information that has changed.

Identification:

Your name: _____

Date of birth: _____ Age: _____

Nicknames or aliases: _____

Home street address:

Apt.: _____

City:

State: _____ Zip: _____

Home/evening phone: _____

Cell phone: _____

Work phone: _____

e-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions:

Is it okay for me to leave a message if I call you? ___yes ___no

Referral Information:

Name of person who referred you to me:

Phone: _____

Address:

May I have your permission to thank this person for the referral? Yes No

Racial / Ethnic / Religious Information:

Current religious denomination/affiliation:

Protestant Catholic Jewish Islamic Buddhist Hindu

Other (please specify):

Involvement: None Some/irregular Active

How important are spiritual concerns in your life?

Ethnicity/national origin: _____

Race: _____

Other way you identify yourself and consider important:

Employment:

Employer: _____

Address: _____

Medical Information:

Clinic/doctor's name:

Phone: _____

Address: _____

If you enter treatment with me for psychological concerns, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment?

Yes No

Are you currently being treated for any medical conditions? If so, what are they?

Are you currently taking any medications? Please include dosages and frequency if you know them.

Have you gained or lost more than 10 pounds recently?

Are you comfortable with your current weight?

Previous Therapy Experience:

Have you ever been in therapy before?

If yes, when and with whom?

For what purpose?

With what results?

Presenting Concerns and Important History:

What brings you to my office today?

Do you currently drink or use any recreational drugs?
If so, how much and how often?

Do you have a history of:
(Please check all that apply)

Physical Abuse Sexual abuse Emotional abuse Financial
abuse

Legal troubles Suicidal thoughts Suicide attempts Attempts
to harm

another person Eating disorders Cutting or other behavior that
injures you

Hospitalization for mental health issues

Please elaborate on any of the items you checked. Use the reverse side of
this form if you
need to.

Is there any other information you think I should know?

Is there anything else you'd particularly like me to ask you about when we
talk?

This is a strictly confidential patient medical record. Law expressly prohibits redisclosure or transfer without your written authorization.