



**Gregory Wells, PhD**

Licensed Psychologist

**CLIENT INFORMATION FORM**

Full Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip code)

Marital Status: \_\_\_\_\_ Date married (if applicable): \_\_\_\_\_

Are you currently in an intimate relationship? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, for how long? \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Referred to Practice By: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

***To (re)schedule appointments, where may I call?***

**Home:** Yes \_ No \_      **Work:** Yes \_ No \_      **Cell:** Yes \_ No \_

May I leave a message on the answering machine?      Yes \_ No \_

May I leave a message with someone at this number?      Yes \_ No \_

Please list any restrictions:

\_\_\_\_\_

***Whom may I contact in case of an emergency?***

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_

**Please complete the following:**

In the space below, please briefly describe the reason(s) for seeking services:

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When did this problem begin?

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What seems to help the problem? \_\_\_\_\_

What seems to make the problem worse? \_\_\_\_\_

**Have you ever had previous counseling or psychotherapy?** Yes  No

If "yes," by whom and when?

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Reason for treatment?

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**Are you currently taking any psychotropic medication** (e.g. antidepressants, anti-anxiety, etc.)?

Yes  No  *If yes, list medication(s), current dosage(s) and reason prescribed:* \_\_\_\_\_

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Name of Psychiatrist: \_\_\_\_\_ Phone: \_\_\_\_\_

**Have you ever been psychiatrically hospitalized?** Yes  No  *If so, when and where?*

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**Have you ever made a suicide attempt/gesture?** Yes  No  *If so, please explain:*

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Have you ever been in trouble with the law? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

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## DEVELOPMENTAL HISTORY

As far as you know, were there any problems with your mother's pregnancy or delivery of you?

Yes \_\_\_ No \_\_\_ If yes, please explain: \_\_\_\_\_

As far as you know, did you walk, talk, and sit up on time? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, please explain: \_\_\_\_\_

Did you have any childhood illnesses, major injuries, or hospitalizations? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

## EDUCATIONAL HISTORY

Schools Attended:

Dates:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Special Education? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, type of class: \_\_\_\_\_

### PLEASE MARK ALL THAT APPLY:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> crying spells           | <input type="checkbox"/> fast heartbeat       | <input type="checkbox"/> money problems           |
| <input type="checkbox"/> unable to have fun      | <input type="checkbox"/> always worried       | <input type="checkbox"/> relationship concerns    |
| <input type="checkbox"/> feelings easily hurt    | <input type="checkbox"/> frequent sweating    | <input type="checkbox"/> work difficulties        |
| <input type="checkbox"/> lacking in confidence   | <input type="checkbox"/> dizziness            | <input type="checkbox"/> sexual problems          |
| <input type="checkbox"/> constipation            | <input type="checkbox"/> shaky hands          | <input type="checkbox"/> can't hold a job         |
| <input type="checkbox"/> feeling grouchy         | <input type="checkbox"/> stomach trouble      | <input type="checkbox"/> excessive drinking       |
| <input type="checkbox"/> always tired            | <input type="checkbox"/> nightmares           | <input type="checkbox"/> excessive medication use |
| <input type="checkbox"/> poor appetite           | <input type="checkbox"/> feeling tense        | <input type="checkbox"/> excessive drug use       |
| <input type="checkbox"/> depressed               | <input type="checkbox"/> cold feet and hands  | <input type="checkbox"/> problems with children   |
| <input type="checkbox"/> trouble sleeping        | <input type="checkbox"/> feeling panicky      | <input type="checkbox"/> problems with parents    |
| <input type="checkbox"/> feeling lonely          | <input type="checkbox"/> diarrhea             | <input type="checkbox"/> poor physical health     |
| <input type="checkbox"/> loss of weight          | <input type="checkbox"/> shy with people      | <input type="checkbox"/> fighting and quarreling  |
| <input type="checkbox"/> not enjoying things     | <input type="checkbox"/> muscle twitching     | <input type="checkbox"/> dislike my body          |
| <input type="checkbox"/> suicidal thoughts       | <input type="checkbox"/> nausea or vomiting   | <input type="checkbox"/> full of energy           |
| <input type="checkbox"/> feeling inferior        | <input type="checkbox"/> can't make decisions | <input type="checkbox"/> overly ambitious         |
| <input type="checkbox"/> loss of sexual interest | <input type="checkbox"/> can't make friends   | <input type="checkbox"/> easily excited           |
| <input type="checkbox"/> no one understands me   | <input type="checkbox"/> headaches            | <input type="checkbox"/> quick tempered           |
| <input type="checkbox"/> worried about health    | <input type="checkbox"/> fainting spells      | <input type="checkbox"/> impatient with people    |

\_\_\_\_\_ can't concentrate

\_\_\_\_\_ can't "get going"

\_\_\_\_\_ feeling angry

\_\_\_\_\_ don't like being alone

\_\_\_\_\_ lack energy

\_\_\_\_\_ unable to relax

\_\_\_\_\_ feeling fearful

\_\_\_\_\_ overly sensitive

\_\_\_\_\_ anxious inside

\_\_\_\_\_ weight gain

\_\_\_\_\_ binge eating

\_\_\_\_\_ very restless

\_\_\_\_\_ feel like hurting someone

\_\_\_\_\_ feel like smashing things

\_\_\_\_\_ excessive overeating

You have been asked a lot of questions. Can you think for a minute and describe any other problems you have that might be related to what you came here for?

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