

# KARIS PSYCHOLOGICAL SERVICES

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LICENCED CLINICAL PSYCHOLOGIST

## Client Information Form

Today's date: \_\_\_\_\_

### A. Identification

Your name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Your nicknames or aliases: \_\_\_\_\_

Home street address: \_\_\_\_\_

Apt.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home/evening phone: \_\_\_\_\_ Calls will be discreet, but please indicate any restrictions: \_\_\_\_\_

### B. Referral: Who gave you my name to call?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

### C. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment?  Yes  No (If Yes, requires PHI Release Form)

### D. Your current employer

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Work phone: \_\_\_\_\_ Calls will be discreet, but please indicate any restrictions: \_\_\_\_\_

### E. Your education and training

Dates		School	Major	Adjustment to school	Did you graduate?
From	To				
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**F. Employment and military experiences**

Dates		Name of military or employers	Job title or duties	Reason for leaving
From	To			
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**G. Family-of-origin history**

Relative	Name	Current age (or age at death)	Illness (or cause of death, if deceased)	Education	Occupation
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Stepparents	_____	_____	_____	_____	_____
Grandparents	_____	_____	_____	_____	_____
Uncles/aunts	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____

**H. Marital/relationship history**

Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Is spouse remarried?
First _____	_____	_____	_____	_____
Second _____	_____	_____	_____	_____
Third _____	_____	_____	_____	_____

**I. Children** (Indicate which are from a previous marriage or relationship with the letter P in the last column)

Name	Current age	Sex	School	Adj problems?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

*This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.*