Dr. Weissman Psychology

PO Box 1968
Agoura Hills, CA 91301
(818) 336-1041 * (805) 601-7098
DrWeissmanPsychology.com

CLIENT INFORMATION

Name: _____ Date: _____

Home Address:_____
Street City Zip Code

Home Phone #: _____ Work Phone #: _____

Cell Phone #:_____ E-mail:_____
Can I leave a message at the above numbers? Yes / No (circle one)

Birth Date:_____ Age: _____ Birth Gender: _____
Month/Day/Year

Name of Guardian(s) (if applicable): _____

Ethnicity: _____ Gender Identity: _____

Employer: _____ Occupation: _____

Marital Status: _____ If married, spouse's name: _____

Referred by: _____ Education/Degree(s) completed: _____

Previous Therapy: _____
Therapist's Name Period of Time Therapy Issue(s)

Physician: _____ Phone #: _____

Please describe your living arrangements:

_____ _____
Name Age Relationship Name Age Relationship

_____ _____
Name Age Relationship Name Age Relationship

In case of emergency, notify: _____ Phone #: _____

Relationship to emergency contact: _____

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Primary Insurance Provider:

_____

Phone: _____

Member ID: _____

Group: _____

Subscriber: _____

Subscriber DOB (M/D/Y): _____

Client's relationship to subscriber:

_____

Primary Insurance Provider:

_____

Phone: _____

Member ID: _____

Group: _____

Subscriber: _____

Subscriber DOB (M/D/Y): _____

Client's relationship to subscriber:

_____

If you would like an invoice provided to you for insurance purposes, please provide an e-mail address where you can receive invoices _____.

Why are you seeking therapy at this time?

_____

_____

_____

_____

_____

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Check any symptoms or behaviors you have exhibited in the past six months:

___ Aggression
___ Alcohol dependence
___ Anger/Hostility
___ Anxiety
___ Appetite/Weight loss
___ Avoiding people
___ Chest pain
___ Chronic pain
___ Cyber addiction (specify)_____
___ Depressed mood
___ Difficulty having fun
___ Difficulty with concentration
___ Disorientation
___ Distractibility
___ Dizziness
___ Drug dependence
___ Elevated mood
___ Excessive fears
___ Excessive gaming
___ Excessive gambling
___ Excessive lying
___ Excessive nightmares
___ Excessive sleep
___ Excessive worrying
___ Fatigue
___ Fidgety
___ Giving up easily
___ Hallucinations
___ Head injury
___ Heart palpitations
___ High blood pressure
___ Hopelessness
___ Impulsivity
___ Irritability
___ Insomnia/Sleeping problems
___ Intrusive thoughts
___ Lack of assertiveness
___ Lethargy
___ Loneliness
___ Long periods of elation
___ Memory impairment
___ Mood shifts
___ Nervousness/Jittery
___ Overeating/Binging
___ Over dependent on others
___ Overly assertive
___ Panic attacks
___ Persistent thoughts
___ Phobias/Fears
___ Recurring thoughts
___ Sadness/Crying spells
___ Self-mutilating behavior
___ Sexual addiction
___ Sexual difficulties
___ Sick often
___ Socially isolated
___ Speech problems
___ Stealing
___ Suicide attempts
___ Suicidal thoughts/Statements
___ Thoughts disorganization
___ Tics
___ Trembling
___ Withdrawing

___ Other (specify): _____

List and describe any history of psychological disorder(s) in your biological family:

_____

_____

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List and describe any significant life events (e.g. divorce, death in family, etc.):

_____

_____

List and describe any current or historical medical/physical health concerns:

_____

_____

List and describe any drug and/or alcohol use (current and/or past):

_____

_____

Have you ever been hospitalized? When? Why? Length of hospitalization?

_____

_____

List any medication(s) and dosage you are currently prescribed:

_____

_____

What are your strengths and hobbies?

_____

_____

The information included in this form is accurate, and I agree to provide updated information should changes occur.

Signature: _____ Date: _____