DR. LUCILLE KEENAN
CLINICAL PSYCHOLOGIST
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CLIENT INFORMATION FORM

NAME:	I PREFER TO BE CALLED:	TODAY'S DATE: / /
DOB: / /	AGE:	SSN: - -
OCCUPATION:	EMPLOYER/SCHOOL:	HIGHEST DEGREE:
PRIMARY CARE PHYSICIAN:	PHONE:	
PSYCHIATRIST:	PHONE:	
HOW DID YOU FIND ME? ❑ REFERRAL ❑ GOOGLE AD ❑ INTERNET SEARCH ❑ PSYCHOLOGY TODAY ❑ OTHER IF REFERRED, WHAT IS YOUR RELATIONSHIP TO PERSON WHO REFERRED YOU? MAY I THANK HIM OR HER? ❑YES ❑NO IF YES, WHOM SHOULD I THANK?		
YOUR CONTACT #'S: MESSAGES OK? (CHECK ONE)❑YES ❑NO	WORK PHONE: ( ) - ❑YES ❑NO	
CELL PHONE: ( ) - ❑YES ❑NO	HOME PHONE: ( ) - ❑YES ❑NO	
EMAIL ADDRESS: ❑YES ❑NO		
RESIDENTIAL ADDRESS:		
EMERGENCY CONTACT:	RELATIONSHIP:	
CELL PHONE: ( ) -	OTHER PHONE: ( ) -	
EMAIL ADDRESS:		
RESIDENTIAL ADDRESS:		
(IF APPLICABLE) SPOUSE/PARTNER NAME:	DATE MARRIED/COMMITMENT CEREMONY?	
SPOUSE/PARTNER EMPLOYER:	SPOUSE/PARTNER HIGHEST DEGREE:	
SPOUSE/PARTNER CELL #: ❑YES ❑NO	SPOUSE/PARTNERWORK #: ❑YES ❑NO	
IF PREVIOUSLY MARRIED THEN SPOUSE'S NAME:	DATE MARRIED: DATE DIVORCED?	

BELOW, PLEASE LIST ALL PREGNANCIES AND CHILDREN (INCLUDE MISCARRIAGE, STILL BORN, TERMINATION). PLEASE NOTE ANY DIFFICULTY CONCEIVING, USE OF ASSISTED REPRODUCTIVE TECHNOLOGY, AND/OR DIFFICULTY WITH PREGNANCY OR BIRTH:

NAMES OF CHILDREN	SEX	AGE/DATE OF BIRTH	NOTE IF ADOPTED OR STEP?

Please list names, ages, and relationship to client of persons residing in household:

Have you ever received psychiatric or psychological help (including a counselor or therapist)? If so, please list provider and dates, city/state, and reason for treatment:

Please list any prescription and over-the-counter medications/supplements, including dosages if known:

Please list any significant illnesses, including allergies:

Do you use alcohol? (check one) ❑Yes ❑No How much?

Do you use other substances? (check one) ❑Yes ❑No What substances? How much?

Do you have any history of eating disorders? (check one) ❑Yes ❑No If so, please describe:

Do you any history of violence against others and/or interaction with the criminal justice system? (check one) ❑Yes ❑No If so, please describe:

Do you have any history of self harm or cutting? (check one) ❑Yes ❑No If so, please describe:

Do you have any history of suicidal thoughts or behavior? (check one) ❑Yes ❑No If so, please describe:

Please note any other information that would be useful for me to know:

Please indicate all of the following issues or problems which pertain to you:

- ❑ STRESS
- ❑ RELAXATION
- ❑ NERVOUSNESS
- ❑ ANXIETY
- ❑ FEARS
- ❑ PHOBIC AVOIDANCE
- ❑ COMPULSIONS
- ❑ NERVOUS TICS
- ❑ HEADACHES
- ❑ CHEST PAINS
- ❑ PALPITATIONS
- ❑ DIZZINESS
- ❑ PAIN
- ❑ HURTING SELF
- ❑ SUICIDAL THOUGHTS
- ❑ SUICIDAL BEHAVIORS
- ❑ RISK-TAKING BEHAVIORS
- ❑ WEIGHT LOSS GAIN
- ❑ EATING PATTERN
- ❑ APPETITE
- ❑ BOWEL TROUBLES
- ❑ STOMACH TROUBLE

- ❑ BINGING
- ❑ VOMITING
- ❑ PURGING
- ❑ HEALTH PROBLEMS
- ❑ MUSCLE TENSION
- ❑ DRUG/ALCOHOL USE
- ❑ HYPOCHONDRIASIS
- ❑ DEPRESSION
- ❑ UNHAPPINESS
- ❑ SLEEP PROBLEM'S
- ❑ LOSS OF INTEREST
- ❑ ENERGY
- ❑ TIREDNESS
- ❑ SELF-WORTH
- ❑ INFERIORITY FEELINGS
- ❑ MEMORY/ CONCENTRATION
- ❑ PURPOSE IN LIFE
- ❑ WITHDRAWAL
- ❑ FITTING IN
- ❑ FRIENDS
- ❑ LONELINESS
- ❑ RELATIONSHIPS
- ❑ DIVORCE

- ❑ SHYNESS
- ❑ PHYSICAL CONTACT
- ❑ BEING TOUCHED
- ❑ SHAME
- ❑ SEPARATION
- ❑ BOREDOM
- ❑ NIGHTMARES
- ❑ SELF-CONTROL
- ❑ TEMPER OUTBURSTS
- ❑ ANGER
- ❑ AGGRESSIVE BEHAVIOR
- ❑ LOSS OF CONTROL
- ❑ SUSPICIOUSNESS OF OTHERS
- ❑ HEARING PROBLEMS
- ❑ GUILT
- ❑ JEALOUS FEELINGS
- ❑ MENSTRUAL PROBLEMS
- ❑ MISCARRIAGE
- ❑ POSTPARTUM DEPRESSION
- ❑ INFERTILITY
- ❑ SEXUAL PROBLEMS
- ❑ MARRIAGE

- ❑ PARENTING
- ❑ CHILDREN
- ❑ PARENTS
- ❑ EDUCATION
- ❑ FINANCES
- ❑ CAREER CHOICES
- ❑ MAKING DECISIONS
- ❑ WORK
- ❑ AMBITION
- ❑ LEGAL MATTERS
- ❑ ABUSE
- ❑ FLASHBACKS
- ❑ VISUAL DISTURBANCE
- ❑ TIME LOSS
- ❑ MY THOUGHTS
- ❑ MY BELIEFS
- ❑ ODD BEHAVIOR
- ❑ FEELING OUT OF BODY
- ❑ FEELING UNREAL
- ❑ HALLUCINATIONS
- ❑ DELUSIONS
- ❑ HEARING THINGS

Briefly describe your reason for seeking help (continue on back of page if necessary):

In the event that the portion your bill for which you are responsible is unpaid for longer than 30 days, and no other arrangements have been made, your credit card will be charged the amount of your balance plus a 5% late fee.

❑ Mastercard / ❑Visa #: Exp. Date: Security Code on Back:

Cardholder's Name: Zip Code:

I attest that, to the best of my knowledge, all of the above information is correct.

Name: **Date:**

If minor, parent, or guardian name:

Signature: **Date:**