Dr. Elizabeth Coldren
CLINICAL PSYCHOLOGIST

PERSONAL INFORMATION WORKSHEET
Please complete before initial session

Name:_____ Date:_____

Social Security Number:_____

Date of Birth:_____

Address:_____

_____

_____

Home Phone: _____>> OK to call? Y N OK to leave message? Y N

Pager/Cell Phone: _____>> OK to call? Y N OK to leave message? Y N

Work Phone: _____ >> OK to call? Y N OK to leave message? Y N

Email address:_____

Gender __F __M Date of Birth _____ Age _____

Relationship Status: __ single __married __ separated __ divorced __ committed relationship

Living With: __ spouse/partner __ parent[s] __ roommate[s] __ children __ other _____

Education: Highest grade completed or highest degree _____

Occupation: _____ Employer: _____

EMERGENCY CONTACT

Name :_____

Relationship to you::_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

MEDICAL HISTORY

Past health problems or illnesses: _____
_____

Past hospitalization? __No__Yes If yes, please explain.

_____
_____
_____
_____

Current physical health concerns: _____
_____
_____

List all prescription medication that you are currently taking:_____
_____
_____

Do you wish for me to have contact with your physician? __No___Yes If yes, please complete a Release of Information Form found under "Forms" on website.

Have you ever been hospitalized for a medical condition?__No__Yes If yes, please explain.

_____
_____
_____
_____

Have you ever been hospitalized for a mental health condition? __No__Yes If yes, please explain.

_____
_____
_____
_____

PREVIOUS THERAPY EXPERIENCE ___ No ___ Yes
If yes, please explain. Please include name of therapist, total number of sessions, and reason for treatment.

_____
_____
_____

Continued on page 3...

PRIMARY INSURANCE: Please also read and sign section tiled “Financial” on Client Information form

Primary Card Holder Name: _____

Insurance Company:_____ Phone: _____

Policy #: _____

Group#:_____

Policy Holder’s Social Security #:_____-____-_____

Policy Holder’s Date of Birth: _____

Policy Holder’s Employer:_____

Please see page 4 to complete “Symptom Checklist”

CURRENT SYMPTOM CHECKLIST (please check all that apply and explain)

___ Work/Career problems
___ Sleep pattern disturbances
___ Nervous or anxious feelings
___ Sadness
___ Sexual problems
___ Guilt/shame
___ Shyness
___ Anger management
___ Dealing with conflict
___ Legal problems
___ Alcohol use or abuse
___ Health/physical illness
___ Aging
___ Identity
___ Concerns about family
___ Physical or sexual abuse or assault
___ Other trauma
___ Cultural/ethnic/racial issues
___ Pregnancy-related problems
___ Sexual orientation issues
___ Grief or loss
___ Impulsiveness
___ Trouble saying no/setting limits
___ Relationship problems
___ Child Custody Issues
___ Repetitive/ intrusive thoughts
___ Motivation problems
___ Concentration problems
___ Loneliness or isolation
___ Panic attacks
___ I have periods where I need very little sleep, think fast, work fast, and feel much happier than usual.
___ Drug use or abuse
___ Eating or body image issues
___ I have used illegal drugs (marijuana, cocaine, pills, etc.) within the past year.
___ I have on average _____alcoholic drinks on days I chose to drink.
___ I have been arrested in the past year.
___ I often go on eating binges.
___ I vomit, take laxatives, or exercise a great deal to control my calorie intake.
___ In the past I have made a suicide attempt.
___ I have been thinking about harming or killing myself:
___ I have thoughts about harming others

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