Fardis Psychology, PLLC

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CLIENT INFORMATION FORM

Date:	First Name:	
Middle Name:	Last Name:	
Phone:	Email:	
Address:		
Emergency Contact:	Emergency Contact's Phone:	
Emergency Contact's Address:		
How do you prefer to be contacted?	Is it ok to send you emails, voice/text messages?	

Date of Birth: ------- / ------- / -------	Age:	Gender:
Ethnic Background (check all that apply or specify below): ☐ African-American ☐ Asian-American / Asian ☐ Hispanic / Latino / Latina ☐ Middle Eastern ☐ Multi-racial ☐ Native American ☐ White / Caucasian ☐ Other (specify): ☐ ---------- ☐ ----------	Education: ---------- Occupation: ---------- Employer: ---------- How many hours a week do you work? ---------- Sexual Orientation: ----------	Do you have any medical illnesses? ---------- ---------- ---------- Medications or herbal supplements? ---------- ---------- ---------- ----------
Religious or spiritual preference: ☐ Buddhist ☐ Christian ☐ Hindu ☐ Jewish ☐ Muslim ☐ Not religious ☐ Other (specify): ☐ ----------	To what extent does your religious/spiritual preference play a role in your life? ☐ Very Important ☐ Important ☐ Neutral ☐ Unimportant	Relationship Status: ☐ Dating or Living together ☐ Married ☐ Single ☐ Other (specify) ☐ ---------- Do you have children? How many? ----------

Do you have a psychiatrist? If so, provide the name please. --- --- ---	Have you attempted or thought about suicide? --- --- ---	Have there been any changes in your life recently? --- --- ---
Your reason for seeking counseling? --- --- ---	Rate the intensity of the problem that brought you here: ☐ Mild ☐ Moderate ☐ Intense	How long have you had this problem? --- ---
How have you attempted to cope with this problem? --- --- ---	What would you like to be different as a result of counseling? --- --- ---	Who suggested that you contact me? --- --- ---
Recently, my feelings include: ☐ Hopeless ☐ Depressed ☐ Shameful ☐ Angry ☐ Guilty ☐ Lonely ☐ Sad ☐ Anxious ☐ Afraid ☐ Numb ☐ Happy ☐ Other (specify) ☐ ---	Recently, my thoughts have been: ☐ Confused ☐ Hopeless ☐ Racing ☐ Obsessive ☐ Distracted ☐ Disorganized ☐ Paranoid ☐ Excited ☐ Slow ☐ Normal ☐ Other (specify) ☐ --- ☐ ---	I have these physical symptoms: ☐ Hearing voices ☐ Seeing things ☐ Sleep problems ☐ Appetite problems ☐ Fatigue ☐ Weight gain or loss ☐ Pain ☐ Tightness in the chest ☐ Dizziness ☐ Numbness or tingling ☐ Rapid heart beat ☐ Other (specify) ☐ ---
I have these behaviors: ☐ Injuring self ☐ Excessive drinking ☐ Using drugs ☐ Eating less or more than usual ☐ Procrastinating ☐ Poor concentration ☐ Crying ☐ Withdrawing socially ☐ Obsessive thinking ☐ Acting aggressively ☐ Disorganization ☐ Impulsivity ☐ Irritability ☐ Other (specify) ☐ ---	Words that describe me: ☐ Worthless ☐ Unmotivated ☐ Unattractive ☐ Unlovable ☐ Confident ☐ Sensitive ☐ Honest ☐ Smart ☐ Capable ☐ Caring ☐ Out of control ☐ Obsessive ☐ Emotional ☐ Other (specify) ☐ ---	What else is important to know about you? --- --- --- --- --- --- --- END OF THE FORM THANK YOU