

Client Information Form
Office of Philip Keddy, Ph.D.
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Please fill out this biographical information background form as completely as possible. It will help me in our work together. Information is confidential as described in the Office Policies and Notice of Privacy Practices. If you do not wish to answer any question, please write "Do not care to answer." Please print or write clearly.

Today's date: _____ *Date of first appointment (if different):* _____

Name: _____

Social Security# : _____
(Only necessary if you are requesting a form for insurance billing)

Date of Birth: _____ *Age:* _____
(Month/day/year)

Place of birth: _____

Ethnicity: _____

Email Address: _____

Current Mailing Address: _____

Telephone (please circle preferred contact number)

Home: _____ *Work:* _____

Cell: _____ *Fax:* _____

Highest grade completed or highest degree: _____

Total years education: _____

Occupation(s) (former, if retired): _____

Referred by: _____

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Relationship status: (circle one) Single Paired Married Separated Divorced Widowed

Name of spouse/partner: _____

Spouse or partner's education: _____ *Occupation:* _____

Person & phone number to call in emergency: _____

Children, including step or grand (please continue on extra page if more)

	<i>Name</i>	<i>Age</i>	<i>Brief description of relationship</i>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

If you are not paying for your treatment yourself, but an organization, parent, spouse or someone else is, please fill this section out. If you are paying yourself, please go on to "Presenting Problem" section.

Name of person/agency responsible for payment:

Relationship to client: _____

Occupation/title: _____

Mailing address: _____

Telephone (please circle preferred contact number)

Home: _____ *Work:* _____

Cell: _____ *Fax:* _____

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Presenting problem or reason for assessment: (please be as specific as you can, including when it started and how it affects you):

Estimate the severity of the problem(s)(circle one) Mild Moderate Severe Very Severe

Parents/ Step-parents (please use extra page at end if more)

<i>Name</i>	<i>Age*</i>	<i>Occupation</i>	<i>Brief description of relationship</i>
<i>Father:</i> _____			

Mother: _____

Step-parents: _____

** (if deceased, please indicate year and cause of death)*

Siblings (please use extra page at end if more)

<i>Name</i>	<i>Age*</i>	<i>Occupation</i>	<i>Brief description of relationship</i>
1. _____			
2. _____			
3. _____			

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**(if deceased, please indicate year and cause of death)*

Medical Doctor(s)
Name

Phone number

Please list all medications you are presently taking (use extra sheet at end if more)

<i>Medication</i>	<i>Dosage</i>	<i>For treatment of</i>
1. _____		
2. _____		
3. _____		

Present alcohol or (non-prescribed) drug use (circle all that you use)

Alcohol Marijuana Cocaine Amphetamines Pain Meds
Tranquilizers (Benzodiazepines) Other _____

Past alcohol or (non-prescribed) drug use (circle all that applied)

Alcohol Marijuana Cocaine Amphetamine Pain Meds
Tranquilizers (Benzodiazepines) Other _____

Twelve-Step Involvement (Circle all that apply)

AA NA MA ALANON ACOA CA SA SLAA

Other: _____

Anniversary date: _____

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Suicide attempt(s) or violent behavior:

<i>Age</i>	<i>Describe event</i>	<i>Reasons or circumstances</i>
<hr/>		
<hr/>		

Family medical history: (please describe any illnesses that run in the family, physical or mental/emotional)

Past (or present) psychotherapy (please use extra page at end if more)

<i>Name of therapist (& degree)</i>	<i>Start Date</i>	<i>End Date</i>	<i>How helpful?</i>
<hr/>			
<hr/>			
<hr/>			

Please describe any important facts about your childhood that have not been mentioned (use extra page if needed):

Thank you for completing this form. The next page is blank and can be used for additional information.

