Beverly A. Brosky, Psy.D., PLLC

Licensed Psychologist

Client Information Form

Date: _____

Demographic Information

Full Name: _____

Address:_____

_____

Home Phone: _____ Okay to leave message Y ___N ___

Work Phone: _____ Okay to leave message Y ___N ___

Cell Phone: _____ Okay to leave message Y ___N ___

How do you prefer I contact you? Home____ Work____ Cell____

Any Call Restrictions on any Phone: _____

Age: _____ Birth Date: _____ Gender: Male_____ Female_____

Marital Status: Never Married: ____ Married____ Partnered____ Divorced____ Separated____ Widowed_____

Occupation: _____ Employer: _____

Past Education: _____

Currently in School/Where? _____

Emergency Contact: _____ Phone_____

Relationship to You_____

Referral Source: _____ Permission to thank person Y___ N___

CHIEF CONCERN

Please describe the main difficulty that brought you to see me:

_____

_____

_____

Dr. Beverly A. Brosky, Psy. D., PLLC Client Information Form

MEDICAL INFORMATION

Primary Care Physician: _____ Phone _____

Date of Last Physical Exam _____ Findings from that Exam _____

_____

Current, ongoing medical conditions (e.g., diabetes, hypertension, heart problems, asthma, head trauma, cancer, etc.

_____

_____

MEDICATION

Please list current medications, dosage, what for, and prescribing physician:

_____

_____

_____

Have you been previously prescribed psychiatric medication (antidepressants, or others)?
Yes_____ No_____

If yes, what medication, dosage, dates began/ended?

_____

_____

Previous Psychotherapy/ Drug/Alcohol Treatment, Mental Health Hospitalization

Have you had previous psychotherapy/counseling, drug or alcohol treatment? Yes____ No____

If yes, from whom, dates, reason (s) for therapy or treatment and was it helpful?

_____

_____

Have you ever been hospitalized for psychiatric reasons? Yes____ No_____

If yes, what hospital, date began/ended, precipitating event? _____

_____

Family History of Mental Health Problems or Chemical Dependency:

_____

_____

Signature: _____ **Date**_____