

Stefanie Maxwell, Psy.D.  
4305 N. Lincoln Ave., Office J  
Chicago, IL 60618

## Client Information Form 1

Today's date: \_\_\_\_\_

Please fill out as much information as you think important.

### A. Identification

Your name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Nicknames or aliases: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home street address: \_\_\_\_\_ Apt.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home/evening phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

Calls or e-mail will be discreet, but please indicate any restrictions: \_\_\_\_\_

### B. Referral: Who gave you my name to call?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

May I have your permission to thank this person for the referral? ☐ Yes ☐ No

How did this person explain how I might be of help to you? \_\_\_\_\_

### C. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ☐ Yes ☐ No

### D. Your current employer

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Work phone: \_\_\_\_\_ or other means of communication \_\_\_\_\_

Calls will be discreet, but please indicate any restrictions: \_\_\_\_\_

(cont.)

### E. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Significant other/nearest friend or relative not residing with you: \_\_\_\_\_

### F. Your education and training

Dates	Schools	Special classes? Adjustment to school	Did you graduate?
From	To		

### G. Employment and military experiences

Dates	Name of employers	Job title or duties	Reason for leaving
From	To		

### H. Religious and racial/ethnic identification

Current religious denomination/affiliation \_\_\_\_\_

Involvement: ☐ None ☐ Some/irregular ☐ Active

How important are spiritual concerns in your life? \_\_\_\_\_

Ethnicity/national origin: \_\_\_\_\_ Race: \_\_\_\_\_ or other similar way  
you identify yourself and consider important: \_\_\_\_\_

### I. Family-of-origin history

Relative	Name	Current age (or age at death)	Illnesses (or cause of death, if deceased)	Education	Occupation
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Father  
Mother  
Brothers

Sisters

Stepparents

Grandparents

Uncles/aunts

Others

**J. Marital/relationship history**

	Spouse's name	Spouse's age	Your age	Has spouse remarried?	Divorced/widowed
First					
Second					
Third					

**K. Significant non-marital relationships**

	Name of other person	Person's age when started	Your age when started	Your age when ended	Reasons for ending
First					
Second					
Third					
Current					

**L. Children** Indicate those from a previous marriage or relationship with "P" in the last column.

Name	Current age	Gender	School	Grade	Adjustment problems?	P?
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**M. Is there any other information you think I should know?**

*This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.*