

Client Information Sheet

Please fill out the following information and answer all questions as clearly and neatly as possible.

Name of client: _____ Date of Birth: _____

Name parent or legal guardian (if applicable): _____

Address: _____

City and Zip code: _____

Preferred phone (home or cell, please specify), and is text messaging permitted for appointment contact ONLY:

() _____

May I leave a message? _____

Have you had previous psychotherapy? Yes or No

If yes, when and for how long? _____

Are you taking any **prescription or non-prescription medication(s)** at this time or on a regular basis? If so, **please list them and their doses**, if you know them, here:

Basic Health Information

How would you describe your physical health at the present time? (circle one)

Poor Unsatisfactory Satisfactory Good Very good Excellent

Do you have any problems with sleep? Yes No

How often do you exercise? never sometimes regularly

Do you have problems with your eating habits/diet? Yes No

Place of employment/job title OR name of school/level:

With whom do you reside?

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