LAUREN FEINER, PSY.D.
Licensed Clinical Psychologist
CA PSY 26049

NEW CLIENT INFORMATION

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender: ____ Sexual Orientation: _____

Occupation: _____ Race/Ethnicity: _____

Social Security No: _____ Religion: _____

Address: _____ Referred by: _____

_____ May I acknowledge referral: Y N

Home Phone: _____ Okay to leave messages? Y N

Work Phone: _____ Okay to leave messages? Y N

Cell Phone: _____ Okay to leave messages? Y N

E-mail: _____ Okay to e-mail you? Y N

Emergency Contact Name: _____ Phone Number: _____

Relationship to Emergency Contact: _____ Marital Status: _____ Years in Relationship: ___

Current Partner/Spouse's name: _____ Age: ____ Occupation: _____

Current Physician: _____ Phone: _____ Last exam: _____

Current Medications	Dose	Purpose

Are you currently receiving psychiatric or mental health services elsewhere? Y N

Current & Previous Mental Health Providers:

Provider Name	Dates of treatment	Contact Information

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Who do you currently reside with?

Name(s)	Relationship	Age(s)

Family History (please mark appropriate boxes √):

	Mother	Father	Sibling(s)	Grandparents	Uncle	Aunt
Alcohol/ Substance Abuse						
Suicide Attempt						
Suicide Completion						
Depression						
Anxiety						
Bipolar Disorder						
Schizophrenia						
ADHD						
Divorce/ Marital Problems						
Significant Physical Illness or Disability						

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Below you will find a list of common challenges people face. Please check any that apply to you at present. Circle the three that bother you most at this point in time.

Anxiety
___ Generalized Anxiety ___ Specific fears/phobias ___ Panic attacks ___ Social Anxiety
___ Obsessive thinking ___ Compulsive behaviors

Mood
___ Sadness or Depression ___ Anger or Irritability ___ Loss of pleasure in life ___ Frequent crying
___ Mania ___ Loss of energy ___ Emotionally overwhelmed
___ Thoughts of suicide ___ Mood Swings

Behaviors
___ Self-harm behavior (cutting/burning/scratching self) ___ Problems with eating
___Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)

Sleep
___ Problems falling asleep ___ Trouble waking up ___ Fatigue/tiredness during the day
___ Problems sleeping through the night ___ Nightmares

Cognitive
___ Problems with attention or concentration ___ Racing thoughts ___ Paranoia
___ Memory Problems

Interpersonal
___ Problems making or keeping relationships ___ Relationship/Marriage problems
___ Problems with intimacy ___ Sexual problems ___ Shyness ___ Family Problems
___ Recent Breakup/Separation/Divorce ___ Difficulties with Assertiveness

Identity
___ Sexuality ___ Self esteem ___ Sense of self ___ Cultural concerns
___ Career choices ___ Personal values ___ Body image concerns

Other
___ History of abuse (emotional, physical, sexual) ___ Problems with job/school
___ Problems with Alcohol or Drugs ___ Financial problems ___ Legal situation
___ Grief or Loss ___ Traumatic experience ___ Medical Problems
___ Racism/ discrimination ___ Other: _____

For Minors:

Year in School: _____ School: _____

Parents/Legal Guardians Names: _____

Thank you for taking the time to fill this form out!