Dr. Margaret Green, Ed.D.,L.P.
Life Skills Institute & Clinic

Client Information Form 1

Today's date: _____

***Note**:* If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Your name: _____Date of birth: _____
Age: _____
Your nicknames or aliases: _____ Social Security #: _____
Home street address: _____
Apt.:_____
City: _____ State: _____Zip: _____
Home/evening phone: _____ Calls 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: _____Calls will be discreet, but please indicate any restrictions:
_____
_____
_____

(cont.)

FORM 22. Client demographic information form (p. 1 of 3). From *The Paper Office,* pp. 201– 203.

E. Your education and training

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

F. Employment and military experiences

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

G. Family-of-origin history

Relative	Name	Current age (or age at death)	Illness (or cause of death, if deceased)	Education	Occupation
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Stepparents	_____	_____	_____	_____	_____

Grandparents _____ _____ _____ _____ _____

Uncles/aunts _____ _____ _____ _____ _____

Brothers _____ _____ _____ _____ _____

Sisters _____ _____ _____ _____ _____

(cont.)

FORM 22. Client demographic information form (p. 2 of 3). From *The Paper Office,* pp. 201– 203.

H. Marital/relationship history

Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Is spouse remarried?
First				
Second				
Third				

I. Significant nonmarital relationships

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

J. Children (Indicate which are from a previous marriage or relationship with the letter P in the last column)

Name	Current age	Sex	School	Grade	Adjustment problems?	P?

_____ _____ _____ _____ ____
_____ __
_____ _____ _____ _____ ____
_____ __
_____ _____ _____ _____ ____
_____ __

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

FORM 22. Client demographic information form (p. 3 of 3). From *The Paper Office,* pp. 201– 203.