Tanya M. Morrel, Ph.D.
and Associates

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Client Information Form

Date:_____Name: _____

Street Address: _____

City:_____State:_____Zip: _____

Home phone:_____Work phone:_____Other phone: _____
Ok to leave message?:___ ___ ___

Date of Birth: _____ Age: _____ Gender:___M___F

Marital Status:___Never married____Married____Separated___Divorced __ Widowed

Religion:_____

Employer Name: _____

Employer Address: _____

Referred by: _____

Have you been in therapy before?____Yes___No When and for how long? _____

Who was your previous therapist? _____

Have you ever been evaluated by a psychiatrist for medication?_____Yes___No

Psychiatrist's Name?_____When? _____

What was the reason? _____

Current medications and dosages prescribed by psychiatrist or other doctor for emotions or behavior

_____,_____, _____

Have you ever been hospitalized for mental health issues?____Yes___No When? _____

Where?_____For how long? _____

Primary Complaints at this Time

Please check **all** that apply:

____Depression	____Substance Abuse	____Eating Problems
____Anxiety	____Sexual Dysfunction	____Panic Attacks
____Post-Traumatic Stress	____Relationship Problems	____Medical Crisis
____Attention Problems	____Grief/Loss	____HIV/AIDS
____Suicidal/Homicidal Thoughts	____Adjustment to New Situation	____Tic Disorder
____Habits or obsessions	____Sleep Problems	____Other

Emergency Contact Information

In case of emergency, whom should I contact? _____

Relationship to you: _____

Phone numbers: _____