Kate Westhoven, PsyD

Licensed Clinical Psychologist

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CLIENT INFORMATION SHEET

Today's Date: _____

Name: _____ **Date of Birth:** _____

Address: _____

Permission to send regular mail, which may include Protected Health Information (PHI) Yes ___ No* ___
*if this is declined, mail will be sent Certified Return Receipt

Email Address: _____

Permission to use this email address to send information which may include PHI Yes ___ No ___

Preferred Phone: _____ OK to leave message? Yes ___ No ___
Alternative Phone: _____ OK to leave message? Yes ___ No ___

Emergency Contact: _____ **Phone:** _____
Address: _____

I give Kate Westhoven, PsyD permission to contact my Emergency Contact person in an emergency.

_____
Signature of Client Date

Please briefly describe your reasons for seeking therapy at this time: _____

_____

_____

_____

Current psychiatrist (or doctor who prescribes psychiatric medications): _____

Current psychiatric medications: _____

Are you currently experiencing any thoughts of suicide? _____

Are you currently experiencing any thoughts of homicide? _____

How many hours of sleep do you get per night? _____

How long does it take you to fall asleep? _____

How many times do you wake during the night? _____

How many alcoholic beverages do you drink per week? _____

Please check all of the following that are concerns and CIRCLE those which are most concerning:

_____ Academic Issues	_____ Aggressive Behavior	_____ Alcohol
_____ Anger	_____ Anxiety	_____ Attention
_____ Body Image	_____ Bullying	_____ Concentration
_____ Diet Issues	_____ Divorce/Separation	_____ Drug Use
_____ Emotional Abuse	_____ Employment/Career	_____ Failure
_____ Family Relationships	_____ Fatigue	_____ Fears
_____ Feelings of Worthlessness	_____ Financial Problems	_____ Food Concerns
_____ Friendships	_____ Gender Identity	_____ Grief
_____ Guilt	_____ Hallucinations	_____ Health/Medical Concerns
_____ High Risk Behavior	_____ Impulsivity	_____ Isolation
_____ Legal	_____ Loneliness	_____ Memory
_____ Mood Swings	_____ Motivation	_____ Mourning
_____ Neglect	_____ Nervousness	_____ Nightmares
_____ Panic Attacks	_____ Parenting Concerns	_____ Phobia(s)
_____ Physical Abuse	_____ Pornography	_____ Prescription Drug use
_____ Procrastination	_____ Relationships	_____ Repeated behaviors
_____ Repeated troubling thoughts	_____ Sadness	_____ Self Injury
_____ Sexual Abuse	_____ Sexual Assault	_____ Sexual Concerns
_____ Sexual Orientation	_____ Sleep	_____ Stress
_____ Verbal Abuse	_____ Violent Behavior	_____ Violent Thoughts
_____ Weight Issues	_____ Worry	_____ Other:_____

Please list all past psychological treatment, including psychotherapy, psychiatry, and hospitalizations: _____

_____

Any past suicidal thoughts or attempts? _____

Any past homicidal thoughts or attempts? _____

Please list significant medical history (chronic conditions, accidents, major illnesses, all surgeries): _____

_____

_____

_____

Signature of Client **Date**