Sarah Hermann Russell, Ph.D., HSPP
Licensed Psychologist

CLIENT INFORMATION

Name of Client: _____ Date of Birth: _____

Age: _____ Client's Cell Phone: _____

Parent's Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

Occupation: _____

Place of Employment: _____

Parent's Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

Occupation: _____

Place of Employment: _____

Marital Status: __ single __ married __ separated __ divorced __ widowed how long? _____

Name of primary care physician: _____

Referred by: _____

Prior counseling

Date of services: _____ Therapist: _____

Major Issues: _____

_____

Medical History

List any current medical problems/allergies: _____

_____

List any medications your child takes on a regular basis: _____

_____

70 E. 91st Street, Suite 201
Indianapolis, IN 46240
(317) 566-2802

Name of School: _____

Grade: _____

Name of teacher: _____

Reason for seeking psychotherapy: _____

_____

_____

Therapy Goals: _____

_____

_____

Referred by: _____

May I send a thank you note to the person who referred you? ___ yes ___ no

_____ _____

Signature (of parent completing form) Date