

**BERT H. EPSTEIN, PSY.D.
CONFIDENTIAL CLIENT INFORMATION SHEET**

The following will help me to serve you better. As with all information you share, this information is treated with professional confidentiality. Please Print.

Please contact me if this information changes.

Date: _____

Your Name: _____
last first middle

Name you would like me to call you (if different than above): _____

Date of Birth: ____ - ____ - ____ Age: _____ Social Security #: _____

Local Address: _____
street city state zip

Please fill in below the number(s) at which I may call you:

Home: (____) _____ - _____ May I leave a message? Yes No

Cell: (____) _____ - _____ May I leave a message? Yes No

Work: (____) _____ - _____ May I leave a message? Yes No

NOTE: EMAIL IS NOT CONSIDERED A SECURE FORM OF COMMUNICATION

Email: _____ May I contact you for scheduling? Yes No

In case of emergency contact: _____
last first
Relationship: _____ Phone (____) _____ - _____

Romantic partnership status:

- Single/Non-Partnered
- Dating
- Significant Relationship
- Married/ Partnered
- Separated
- Divorced
- Other _____
- Decline to Respond

Ethnic identity/background:

- African American/Black
- American Indian/Alaskan Native
- Asian American
- Chicano/Latino/Hispanic
- European American/Caucasian/White
- International
- Multi-ethnic/racial
- Pacific Islander
- Other _____
- Decline to Respond

Gender identity (please check all that apply):

- Female
- Male
- Transgender
- Intersex
- Other _____

Who referred you to me: (check all that apply)

- Family
- Doctor...Name: _____
- Friend
- Therapist...Name: _____
- Romantic Partner/Spouse
- Presentation... Which? _____
- Self
- Insurance Co...Which? _____
- Telephone Book
- Web Site...Which? _____
- Other _____

Employment History:

Current _____

Which Calendar Years: _____

Previous _____

Which Calendar Years: _____

Previous _____

Which Calendar Years: _____

Previous _____

Which Calendar Years: _____

Previous _____

Which Calendar Years: _____

Educational History:

My family has a history of: (check all that apply)

- Abuse
- Alcoholism
- Counseling
- Depression
- Eating Disorders
- Poor Communication
- Psychiatric Hospitalization
- Other _____
- None of these

Who lives with you?

- Children
- Romantic Partner
- Spouse
- Parent(s)
- Roommate
- Other: _____

Do you have dependents? (i.e., a son, daughter)

- Yes No

List Name and Ages: _____

Tell me about the people who raised you:

(check all that apply)

- Biological parents
- Adoptive parents
- Other _____
- Married/Partnered
- Never Married
- Living Together
- Separated (Date: _____)
- Divorced (Date: _____)
- Father Deceased (Date: _____)
- Mother Deceased (Date: _____)

Number of brothers/sisters:

- 0
- 1-2
- 3 or more

Are you currently (or within the past year) under the care of a medical doctor? Yes No

If yes, who and for what condition: _____

Do you have any other significant medical conditions? Yes No

If yes, please describe: _____

Are you currently taking any medications or herbs specifically for a mental health condition? Yes No

Name of medication/herb(s): _____

Who prescribed it for you? _____

Are you currently taking any other medications or herbs? Yes No

Name of medication/herb(s): _____

Who prescribed it for you? _____

Do you have a disability? Yes No

Please describe: _____

Have you had previous counseling or psychotherapy? Yes No

Where? _____

Name of counselor? _____

The Year(s) and Number of Sessions: _____

Previous Therapists- Years- Names:

Are you presently receiving counseling or psychotherapy from some other person or agency?

Yes No

Where? _____

Name of counselor? _____

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I have suffered a recent loss:

- Death
- Relationship ending
- Does not apply
- Other _____

I use alcohol/other drugs

- Once a week or less
- More than once a week
- Do not use

I have had an unwanted sexual experience:

(check all that apply)

- Before age 18
- 18 or older
- No
- Unsure
- Decline to respond

The following has resulted from my alcohol/drug use: (check all that apply)

- Academic problems
- Black outs
- Difficulties with memory
- Fight with friend
- Ruined relationship
- Traffic violation
- Other (specify): _____
- Does not apply

Please indicate the degree to which each of these has been a problem/concern in the past month:

- | | no | little | moderate | significant | |
|----|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|
| 1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sleeping |
| 2 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mood shifts |
| 3 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Appetite |
| 4 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Worthlessness/guilt |
| 5 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Concentration |
| 6 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Memory |
| 7 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Low energy/fatigue |
| 8 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headaches |
| 9 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sex |
| 10 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Weight loss/gain |
| 11 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety |
| 12 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Panic |
| 13 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sadness/depression |
| 14 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Relationships |
| 15 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Getting extremely angry |
| 16 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Trusting other people |
| 17 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Absent from work or class too often |
| 18 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Indecision about career |
| 19 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Social Performance Anxiety |
| 20 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | My sexual identity/orientation |
| 21 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Too easily influenced by others |
| 22 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Financial problems |
| 23 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | I don't like my body |
| 24 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | My religious/spiritual beliefs |
| 25 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HIV or other STD concerns |
| 26 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Wasting time on the computer |
| 27 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | My substance use |
| 28 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gambling |
| 29 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thoughts of ending my life |
| 30 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Intentions of ending my life |
| 31 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thoughts of harming someone |
| 32 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Intentions of harming someone |

MY MAIN GOAL FOR THIS THERAPY IS: _____