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 <u>all</u> 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:

____
____
____
____

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: ____________________

My family has a history of: (check all that apply)
☐ Abuse
☐ Alcoholism
☐ Counseling
☐ Depression
☐ Eating Disorders
☐ Poor Communication
☐ Psychiatric Hospitalization
☐ Other ____________________________
☐ None of these

Tell me about the people who raised you:
(check all that apply) ______
☐ Biological parents / Father Deceased (Date:______)
☐ Adoptive parents / Mother Deceased (Date:______)
☐ Other
Number of brothers/sisters: ________ ☐
☐ 0 / Married/Partnered
☐ 1-2 / Never Married
☐ 3 or more / Living Together
☐ Separated (Date:)
☐ Divorced (Date:)

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 ☐ Where? No ☐

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	☐	☐	☐	☐	Sleeping
2	☐	☐	☐	☐	Mood shifts
3	☐	☐	☐	☐	Appetite
4	☐	☐	☐	☐	Worthlessness/guilt
5	☐	☐	☐	☐	Concentration
6	☐	☐	☐	☐	Memory
7	☐	☐	☐	☐	Low energy/fatigue
8	☐	☐	☐	☐	Headaches
9	☐	☐	☐	☐	Sex
10	☐	☐	☐	☐	Weight loss/gain
11	☐	☐	☐	☐	Anxiety
12	☐	☐	☐	☐	Panic
13	☐	☐	☐	☐	Sadness/depression
14	☐	☐	☐	☐	Relationships
15	☐	☐	☐	☐	Getting extremely angry
16	☐	☐	☐	☐	Trusting other people
17	☐	☐	☐	☐	Absent from work or class too often
18	☐	☐	☐	☐	Indecision about career
19	☐	☐	☐	☐	Social Performance Anxiety
20	☐	☐	☐	☐	My sexual identity/orientation
21	☐	☐	☐	☐	Too easily influenced by others
22	☐	☐	☐	☐	Financial problems
23	☐	☐	☐	☐	I don’t like my body
24	☐	☐	☐	☐	My religious/spiritual beliefs
25	☐	☐	☐	☐	HIV or other STD concerns
26	☐	☐	☐	☐	Wasting time on the computer
27	☐	☐	☐	☐	My substance use
28	☐	☐	☐	☐	Gambling
29	☐	☐	☐	☐	Thoughts of ending my life
30	☐	☐	☐	☐	Intentions of ending my life
31	☐	☐	☐	☐	Thoughts of harming someone
32	☐	☐	☐	☐	Intentions of harming someone

MY MAIN GOAL FOR THIS THERAPY IS: ____