

CAROL UMMEL LINDQUIST, PH.D., FACLINP

C L I N I C A L P S Y C H O L O G I S T

THE PSYCHOLOGY CENTER
380 GLENNEYRE SUITE D
LAGUNA BEACH, CA 92651

Client Information

Full Name: _____
 first middle last

Address: _____
 street city state zip

Home Phone:() _____ Work Phone: () _____ Cell Phone: () _____

Please circle preferred phone above for messages. As a courtesy, we notify you of next days appointment. Please check here if you do not want to be reminded:

Birthdate: _____ Age: _____ Social Security #: _____

Occupation/Job Title: _____ Employer: _____

Employment Address: _____

Length of time on job: _____ Email: _____

Spouse/Partner Information

Name: _____ Years Married: _____

Birthdate: _____ Age: _____ Social Security #: _____

Occupation/Job Title: _____ Employer: _____

Employment Address: _____

Name of Referral: _____ Date: _____

(May we contact them to thank them) (Yes) (No) Phone #: _____

Person To Notify In Case of Emergency (Other Than Spouse)

Name: _____ Relationship to You: _____

Address: _____ Phone: () _____

Therapy Goals:

Briefly describe or list your goals for therapy: _____

Current Symptoms/Problem and Background Information

Briefly describe reason for seeking help: _____

Approximate date these problems/symptoms first appeared: _____

Have you ever had these problems/symptoms before? Yes No If Yes, when? _____

Approximate date of last physical examination/visit to your (name of) M.D.? _____

For what reason(s)? _____

List current health problems: _____

List names and telephone numbers of Physicians concurrently treating you and indicate if we may contact them should the need arise: _____

List the members of your family and all others living with you at this time:

Name	Age	Relationship	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Prior History of Psychological/Psychiatric Treatment or Treatment for Alcohol or Drug Problems

Dates Problem Outpt/Inpt Name of MD/Therapist (Phone if known)

If you drink alcoholic beverages, please indicate which kind and how often:

If you use drugs of any kind, including prescription medications and/or street drugs, please indicate which kind, for what purpose, the dosage/amount and frequency:

Drugs (marijuana, cocaine, ecstasy, prescription) Purpose Dosage/Frequency

Have you seen a Chiropractor, Physical Therapist, or Alternative Healer? _____

Name & how recently _____

Names and relationship to you of family members in which there has been a drinking or drug problem (include grandparents, aunts or uncles):

Have you or has anyone in your family had an eating problem (e.g. overeating, anorexia, bulimia)?

Yes No If yes, who? _____

Have you been a victim of physical, sexual or emotional abuse or neglect? Yes No

If yes, by whom?

Do you currently have any legal problems? Yes No If yes, please describe:

Symptom Checklist

Please circle any of the following problems that apply to you: Number the most important.

- | | | | |
|-------------------|----------------------|------------------|----------------|
| Nervousness | Depression | Fears | Shyness |
| Sexual Problems | Suicidal Thoughts | Separation | Divorce |
| Finances | Drug Use | Alcohol Use | Friends |
| Anger | Self Control | Unhappiness | Sleep |
| Stress | Work | Relaxation | Headaches |
| Tiredness | Legal Matters | Memory | Ambition |
| Energy | Insomnia | Making Decisions | Loneliness |
| Concentration | Health Problems | School | Career Choices |
| Marriage Problems | Temper | Nightmares | Appetite |
| Stomach Trouble | Bowel Troubles | Being a Parent | My thoughts |
| Children | Inferiority Feelings | My parents | Education |
| Self Confidence | Anxiety | Aging | Guilt |

Menopause Issues

List parents, step-parents, siblings and any children of yours and/or your spouse who do not live with you:

Name	Age	Relationship	Occupation

Thank you for your time and attention in completing this information form.

Rev. 4/00

(Optional) Insurance Information (if you wish us to inquire about benefits)

Name of Insurance Company: _____

Address of Insurance Company: _____

Insured's Name: _____ Social Security #: _____

Plan #: _____ Group #: _____ Insured's Employer: _____