CAROL UMMEL LINDQUIST, PH.D., FACLINP
CLINICAL PSYCHOLOGIST

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

Client/Coaching Client Information

Full Name: _____
first middle last

Address: _____
street city state zip

Cell Phone:( )_____Work Phone: ( )_____ Home Phone: ( )_____

Reminders: As a courtesy, we remind you of next day's appointment. Please check preferred notice ☐Text ☐Email
Please check here if you do not want to be reminded: ☐

Birthdate: _____ Age: _____ Social Security #:XXX-XX-( )

Occupation/Job Title: _____ Employer: _____

Employment Address: _____

Length of time on job: _____ Email Address:_____

Spouse/Partner Information

Name:_____ Time Together: _____

Birthdate: _____ Age: _____ Email Address: _____

Occupation/Job Title:_____ Employer: _____

Name of Referral_____

(May we contact them to thank them?) ☐ Yes ☐ No If yes, Phone #: _____

Person to Notify in Case of Emergency (Other Than Spouse/Partner)

Name:_____ Relationship to You: _____

Address: _____ Phone: ( )_____

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 physician? _____

Physician Name _____ For what reason(s)? _____

List any current health problems: _____

_____

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

_____

_____

_____

Have you seen a Chiropractor, Physical Therapist, or Alternative Healer? ☐ Yes ☐ No

Name & how recently seen_____

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

Name	Age	Relationship	Occupation

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

Name	Age	Relationship	Occupation

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

Problem Dates Response 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 or street drugs, please indicate which kind, for what purpose, the dosage/amount and frequency:

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

_____

_____

Names and relationship to you of family members with whom 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, neglect or other trauma? ☐ Yes ☐ No
If yes, by whom and in what situation or relationship?

_____

_____

Are you currently involved in any legal matters? ☐ Yes ☐ No If yes, please describe:

_____

_____

_____

Symptom Checklist

Please circle any of the following problems that apply to you:
Number the most important in order (1 is first priority)

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			

Considering your issues, what is the goal you would like to most achieve first in therapy?

_____

_____

_____

_____

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