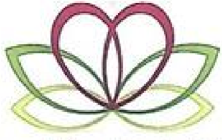

Norwood Psychological Group

Melvina Norwood, Ph.D.
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CLIENT INFORMATION FORM

This Form is Confidential

Your name: ____
Last First Middle Initial

Date of birth: ________________ Today's date: ______________ Social Security #: ______________________

Home street address: ____

City: ___________________________________ State: _________ Zip: __________________

Name of Employer: ____

Address of Employer: ____

City: ___________________________________ State: _________ Zip:__________________

Home Phone: _______________________ Work Phone: ________________________________
Cell Phone: ________________________ Email: _____________________________________

Calls will be discreet, but please indicate any restrictions: __________________________________
____

Referred by: ____

May I have your permission to thank this person for the referral?

- Yes • No

If referred by another clinician, would you like for us to communicate with one another?

- Yes • No

Person(s) to notify in case of any emergency: ____
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): ______________________________

Please briefly describe your presenting concern(s):

____
____
____
____
____

What are your goals for therapy?

____
____
____
____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? ____________________________

**The following information on this form will help guide your treatment.*
*Please try to fill out as much as you are comfortable disclosing.**

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses:

____
____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day?____________________

Do you consume caffeine? YES NO If YES, how much per day? ____________________

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? ____

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? ____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons): ____________________________________
____
____

Previous psychiatric hospitalizations (Approximate dates and reasons):__________________________________
____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons):
____
____
____

Height _________ Weight (if applicable) _________ Age_________ Gender _________

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual __Transgender
__ Asexual __ In Question __Other: _________________

Racial/Ethnic Identity:
__African/African-American/Black __ Latino/Latino-American __Bi-Racial/Multi-Racial
__American Indian/Alaska Native __ Middle Eastern/Middle Eastern-American
__Asian/Asian-American/Asian Pacific Islander __White/European-American __Not listed

FAMILY:

How would you describe your relationship with your mother? ______________________________
____
____

How would you describe your relationship with your father? ______________________________
____
____

Are your parents still married? _____________
If they divorced, how old were you when they separated or divorced, and how did this impact you?
____
____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: ____________________________________
____

How many sisters do you have? ______ Ages? ___________________________________
How many brothers do you have? ______ Ages? __________________________________
How would you describe your relationships with your siblings? ___________________________
____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: (POOR) 1 2 3 4 5 6 7 (EXCELLENT)

Married/Life Partnered? _____ How Long? ____ Previously Married/Life Partnered? YES NO

If so, length of previous marriages/committed partnerships ____________________________________

Do you have Children?____ If YES, how many and what are their ages: _______________________________
Describe any problems any of your children are having: ____
____

List the names and ages of those living in your household: ____
____

Please briefly describe any history of abuse, neglect and/or trauma:
____
____
____
____

Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

Please briefly describe your coping mechanisms and self-care:
____
____
____
____

Is spirituality important in your life and if so please explain: ____
____
____
____

Briefly describe your diet and exercise patterns:
____
____
____

EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree(or Higher)___ Vocational Degree___

What is your current employment? ____

Employment Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Any past career positions that you feel are relevant?
____
____

What do you think are your strengths? ____
____
____

PLEASE CHECK ALL THAT APPLY & *CIRCLE* THE MAIN PROBLEM:

	Difficulty with:	**NOW**	**PAST**		**Difficulty with:**	**NOW**	**PAST**		**Difficulty with:**	**NOW**	**PAST**	
	Anxiety				People in General				Nausea			
	Depression				Parents				Abdominal Distress			
	Mood Changes				Children				Fainting			
	Anger or Temper				Marriage/Partnership				Dizziness			
	Panic				Friends(s)				Diarrhea			
	Fears				Co-Worker(s)				Shortness of Breath			
	Irritability				Employer				Chest Pain			
	Concentration				Finances				Lump in the Throat			
	Headaches				Legal Problems				Sweating			
	Loss of Memory				Sexual Concerns				Heart Palpitations			
	Excessive Worry				History of Child Abuse				Muscle Tension			
	Feeling Manic				Hitory of Sexual Abuse				Pain in Joints			
	Trusting Others				Domestic Violence				Allergies			
	Communicating with others				Thoughts of hurting someone else				Often Make Careless Mistakes			
	Drugs				Hurting Self				Fidget Frequently			
	Alcohol				Thoughts of Suicide				Speak Without Thinking			
	Caffeine				Sleeping too Much				Waiting Your Turn			
	Frequent Vomiting				Sleeping too Little				Completing Tasks			
	Eating Problems				Getting to Sleep				Paying Attention			
	Severe Weight Gain				Waking too Early				Easily Distracted by Noise			
	Severe Weight Loss				Nightmares				Hyperactivity			
	Blackouts				Head Injury				Chills or Hot Flashes			

FAMILY HISTORY OF (Check all that apply):

	Drug/Alcohol Problems			Physical Abuse			Depression		
	Legal Trouble			Sexual Abuse			Anxiety		
	Domestic Violence			Hyperactivity			Psychiatric Hospitalization		
	Suicide			Learning Disabilities			“Nervous Breakdown”		

Any additional information you would like to include:
____
____
____
____