



Dr. Elizabeth Coldren

CLINICAL PSYCHOLOGIST

PERSONAL INFORMATION WORKSHEET

Please complete before initial session

Name: _____ Date: _____

Social Security Number: _____

Date of Birth: _____

Address: _____

Home Phone: _____ >> OK to call? Y N OK to leave message? Y N

Pager/Cell Phone: _____ >> OK to call? Y N OK to leave message? Y N

Work Phone: _____ >> OK to call? Y N OK to leave message? Y N

Email address: _____

Gender F M Date of Birth _____ Age _____

Relationship Status: single married separated divorced committed relationship

Living With: spouse/partner parent[s] roommate[s] children other _____

Education: Highest grade completed or highest degree _____

Occupation: _____ Employer: _____

EMERGENCY CONTACT

Name : _____

Relationship to you: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

MEDICAL HISTORY

Past health problems or illnesses: _____

Past hospitalization? No Yes If yes, please explain.

Current physical health concerns: _____

List all prescription medication that you are currently taking: _____

Do you wish for me to have contact with your physician? No Yes If yes, please complete a Release of Information Form found under "Forms" on website.

Have you ever been hospitalized for a medical condition? No Yes If yes, please explain.

Have you ever been hospitalized for a mental health condition? No Yes If yes, please explain.

PREVIOUS THERAPY EXPERIENCE No Yes
If yes, please explain. Please include name of therapist, total number of sessions, and reason for treatment.

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PRIMARY INSURANCE: Please also read and sign section titled “Financial” on Client Information form

Primary Card Holder Name: _____

Insurance Company: _____ Phone: _____

Policy #: _____

Group#: _____

Policy Holder’s Social Security #: _____ - _____ - _____

Policy Holder’s Date of Birth: _____

Policy Holder’s Employer: _____

Please see page 4 to complete “Symptom Checklist”

CURRENT SYMPTOM CHECKLIST (please check all that apply and explain)

- Work/Career problems
- Sleep pattern disturbances
- Nervous or anxious feelings
- Sadness
- Sexual problems
- Guilt/shame
- Shyness
- Anger management
- Dealing with conflict
- Legal problems
- Alcohol use or abuse
- Health/physical illness
- Aging
- Identity
- Concerns about family
- Physical or sexual abuse or assault
- Other trauma
- Cultural/ethnic/racial issues
- Pregnancy-related problems
- Sexual orientation issues
- Grief or loss
- Impulsiveness
- Trouble saying no/setting limits
- Relationship problems
- Child Custody Issues
- Repetitive/ intrusive thoughts
- Motivation problems
- Concentration problems
- Loneliness or isolation
- Panic attacks
- I have periods where I need very little sleep, think fast, work fast, and feel much happier than usual.
- Drug use or abuse
- Eating or body image issues
- I have used illegal drugs (marijuana, cocaine, pills, etc.) within the past year.
- I have on average _____ alcoholic drinks on days I chose to drink.
- I have been arrested in the past year.
- I often go on eating binges.
- I vomit, take laxatives, or exercise a great deal to control my calorie intake.
- In the past I have made a suicide attempt.
- I have been thinking about harming or killing myself:
- I have thoughts about harming others

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