BRIAN KEHOE, PHD
LICENSED CLINICAL PSYCHOLOGIST

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Client Information Form

Today's Date: _____

I. Identification

Your name: _____ Date of birth: _____ Age: _____

Nicknames or aliases: _____

Social Security #: _____ DBN # (Military Only): _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Employer: _____ Address (city ok): _____

Your Position: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ e-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

By which method would you prefer to receive appointment reminders? ☐Text ☐e-mail ☐Phonecall

II. Insurance Information

Insurance Company: _____ Plan Name: _____

Subscriber I.D. (the person who is the primary insurance holder):

_____

Member I.D. (if different from subscriber): _____

Group Number: _____

Subscriber Name: _____ Subscriber Date of Birth:

_____

Subscriber Place of Employment:

_____

Military Only:

Benefits Number: _____ DOD I.D. Number: _____

Sponsor Name: _____ Relationship to Sponsor: _____

III. How did you hear about Dr. Kehoe?

❑ Insurance Company Provider Listing (please list insurer) _____

❑ Yelp Listing ❑ Google Maps Listing ❑ The Provider's Website ❑ Psychology Today Listing

❑ Referred by Someone (please complete below) ❑ Other: _____

Referred By: _____ Address (city ok):

_____

May we have your permission to thank this person for the referral? ❑ Yes ❑ No

How did this person explain how Dr. Kehoe might be of help to you?

_____

_____

IV. Self-Identity

Race/Ethnicity

Ethnicity/national origin: _____ Race: _____

Other related way you identify yourself and consider important:

_____

Religion/Spirituality

Current religious denomination/affiliation: _____

Religious/Spiritual Involvement: ❑ None ❑ Some/Irregular ❑ Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting are you involved with?

_____

Gender & Sexual Identity

Gender Identity (check one): □ Female

□ Male

□ Transgender (non-identification with the sex assigned at birth)

Sexual Orientation (check one):

□ Asexual (lack of sexual interest in either men or women)

□ Bi-Sexual (sexual interest in both men and women)

□ Gay (sexual interest in a member of the same sex)

□ Heterosexual (sexual interest in a member of the opposite sex)

□ Lesbian (sexual interest in a women by women)

□ Questioning (still exploring or unsure of sexual orientation)

V. Health Information

Emergency Contact

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

Address: _____

General Health History

Starting with your childhood and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had.

Age	Illness/Diagnosis	Treatment(s) Received	Treated By	Outcome

Please list any prior mental health treatment you received and the diagnosis, if any. Include visits to a therapist, counselor, psychiatrist, psychologist, social worker, or mental health clinic, as well as any psychiatric hospitalizations, substance abuse treatment, or other residential treatment facilities.

Age	Illness/Diagnosis	Treatment(s) Received	Treated By	Outcome

List all medications, drugs, or other substances you take or have taken in the last year including prescribed medications, over-the-counter vitamins, herbs, and others.

Medication/drug/vitamin/herb	Dosage	Taken for how long?	Prescribed and supervised by

Please list any work you have done during which you may have been exposed to toxic chemicals:

Dates	Type of Work	Types of Chemicals	Effects (Confirmed or Suspected)

Please list any allergies you have:

_____

_____

From whom do you currently receive medical care?

Clinic/doctor's name: _____ Phone: _____

Address (City is OK): _____

Are you currently seeing another mental health care provider (psychologist, psychiatrist, marriage and family therapist, counselor, social worker)?

Provider's name & title: _____ Phone: _____

Address (City is OK): _____

How long have you been under this provider's care?

_____

Reason for care: _____

Do you plan to continue care with the above provider?

_____

Please list any other physicians or mental health care providers who have treated you in the *last 5 years*:

Name of Physician or Agency	Speciality	Location (City, State)	Date of Last Visit (Month/Year)

Health Habits

1. **What kinds of physical exercise do you get?**

_____

_____

2. **How much coffee, cola, tea, or other sources of caffeine do you consume each day?**

_____

_____

3. **Do you try to restrict your eating in any way?** YES NO (Circle one)

   If yes, describe how: _____

   If yes, describe why: _____

4. **Do you have any problems getting enough sleep?** YES NO (Circle one) **Hrs. of Sleep/Night**: _____

   If yes, what problems (falling asleep, staying asleep)?

   _____

5. **Do you use tobacco?** YES NO (Circle one)

   If yes, how many cigarettes/cigars/other do you use each day?

   _____

6. **Do you drink alcohol?** YES NO (Circle one)

   If yes, how many drinks do you have each day?

   _____

7. **Do you use recreational drugs?** YES NO (Circle one)

   If yes, what drugs and how much/how often?

   _____

   _____

8. **Have you ever injected drugs?** YES NO (Circle one)

   If yes, have you ever shared needles? YES NO (Circle one)

9. **Have you had an HIV test in the last year?** YES NO (Circle one)

If yes, result:

_____

Menstruation *(Women Only):*

1. At what age did you start to menstruate (get your period):

   _____

2. How regular is your period?

   _____

3. How long does your period typically last?

   _____

4. Do you experience pain with your period? If so, how severe is the pain?

   _____

5. Do you experience mood changes with your period? If so, please describe:

   _____

   _____

6. How heavy are your periods?

   _____

7. Other experiences during periods?

   _____

Menopause *(Women Only):*

1. If your menopause has started, at what age did it start? _____
2. What signs or symptoms have you had?

   _____

Please list all of pregnancies *(Women Only):*

Age at Time of Pregnancy	Outcome of Pregnancy (Miscarriage, Abortion, Delivery)	If you gave birth, were there any problems with the delivery? If so, please describe.

Are there any other medical or physical problems you are concerned about?

_____

_____

VI. Reason for Visit:

In your own words, please describe what brings you here today:

_____

_____

_____

_____

_____