

MATERNA PSYCHOLOGICAL SRVS, PC  
701 N. HERMITAGE ROAD  
HERMITAGE, PA 16148

**Client Information Form I**

Today's date: \_\_\_\_\_

Note: If you have been a patient here before, please fill in only the information that has changed.

**A. Identification**

Your name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Nicknames or aliases: \_\_\_\_\_

Home street address: \_\_\_\_\_ Apt.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home/evening phone: \_\_\_\_\_

Calls \_\_\_\_\_ will be discreet, but please indicate any restrictions: \_\_\_\_\_

**B. Referral: Who gave you my name to call?**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

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

How did this person explain how I might be of help to you? \_\_\_\_\_

**C. Your medical care: From whom or where do you get your medical care?**

Clinic/doctor's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment?  Yes  No

**D. Your current employer**

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Work phone: \_\_\_\_\_ Calls will be discreet, but please indicate any restrictions: \_\_\_\_\_

(cont.)

**E. Your education and training**

Dates		Schools	Special classes?	Adjustment to school	Did you graduate?
From	To				

**F. Employment and military experiences**

Dates		Name of military or employers	Job title or duties	Reason for leaving
From	To			

**G. Family-of-origin history**

Relative	Name	Current age (or age at death)	Illnesses (or cause of death, if deceased)	Education	Occupation
Father					
Mother					
Stepparents					
Grandparents					
Uncles/aunts					
Brothers					
Sisters					

(cont.)

**H. Significant nonmarital relationships**

	Name of other person	Person's age when started	Your age when started	Your age when ended	Reasons for ending
First					
Second					
Third					
Current					

**I. Marital/relationship history**

	Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Is spouse remarried?
First					
Second					
Third					

**J. Children** (Indicate which are from a previous marriage or relationship with the letter P in the last column)

Name	Current age	Sex	School	Grade	Adjustment problems?	P?

*This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.*

**MEDICATIONS**

CLIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

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1) Are you, or have you ever been, allergic to any medication? \_\_\_Yes \_\_\_No If Yes, please list:

\_\_\_\_\_  
\_\_\_\_\_

2) Have you ever had an adverse reaction to any medication? \_\_\_Yes \_\_\_No If Yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

3) Please list below any current medications you are taking:

PHYSICIAN	DATE	PRESCRIPTION	DOSAGE	PURPOSE

**Client Information Form 2**

**Note:** If you were a patient here before, please fill in only the information that has changed.

**A. Identification**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**B. Chief concern**

Please describe the main difficulty that has brought you to see me: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**C. Treatment**

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?  
 No  Yes If yes, please indicate:

When?	From whom?	For what?	With what results?

2. Have you ever taken medications for psychiatric or emotional problems?  No  Yes If yes, please indicate:

When?	From whom?	Which medications?	For what?	With what results?

(cont.)

**D. Relationships in your family of origin.** Please describe the following:

1. Your parents' relationship with each other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
2. Your relationship with each parent and with other adults present: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
3. Your parents' physical health problems, drug or alcohol use, and mental or emotional difficulties: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
4. Your relationship with your brothers and sisters, in the past and present: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**E. Abuse history:**  I was not abused in any way.  I was abused. If you were abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect. E = Emotional, such as humiliation, etc.

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?

**F. Present relationships**

1. How do you get along with your present spouse or partner? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
2. How do you get along with your children? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(cont.)

3. Your important friends, past and present:

Names	Good parts of relationship	Bad parts of relationship

**G. Chemical use**

1. Have you ever felt the need to cut down on your drinking?  No  Yes
2. Have you ever felt annoyed by criticism of your drinking?  No  Yes
3. Have you ever felt guilty about your drinking?  No  Yes
4. Have you ever taken a morning "eye-opener"?  No  Yes
5. How much beer, wine, or hard liquor do you consume each week, on the average? \_\_\_\_\_
6. Are there times when you drink to unconsciousness, or run out of money as a result of drinking? \_\_\_\_\_
7. How much tobacco do you smoke or chew each week? \_\_\_\_\_
8. Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner?  No  Yes If yes, which and when? \_\_\_\_\_
9. Which drugs (not medications prescribed for you) have you used in the last 10 years? \_\_\_\_\_

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**H. Legal history**

1. Are you presently suing anyone or thinking of suing anyone?  No  Yes If yes, please explain: \_\_\_\_\_
2. Is your reason for coming to see me related to an accident or injury?  No  Yes If yes, please explain: \_\_\_\_\_
3. Are you required by a court, the police, or a probation/parole officer to have this appointment?  No  Yes If yes, please explain: \_\_\_\_\_

(cont.)

4. List all the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones. Under "Jurisdiction," write in a letter: F = federal, S = state, Co = county, Ci = city. Under "Sentence," write in the time and the type of sentence you served or have to serve (AR = accelerated or alternate resolution, CS = community service, F = fine, I = incarceration, Pr = probation, Po = parole, O = other, R = restitution).

Date	Charge	Jurisdiction (F, S, C, Ci)	Sentence (AR, I, Pr, Pa)	Probation/parole officer's name	Your attorney's name

5. Your current attorney's name: \_\_\_\_\_ Phone: \_\_\_\_\_

6. Are there any other legal involvements I should know about? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I. Other**

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please do not write below this line.

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