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Client Information Form

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: _____

Social Security #: _____

Home street address: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Cell phone: _____

e-mail: _____

Calls or e-mail 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. Religious and racial/ethnic identification

Current religious denomination/affiliation Protestant Catholic Jewish Islamic Buddhist Hindu

Other (specify): _____

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?

Ethnicity/national origin: _____ Race: _____ or other

similar way you identify yourself and consider important:

D. 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

E. Your current employer

Employer: _____

Address: _____

Work phone: _____ or other means of communication _____

Calls will be discreet, but please indicate any restrictions:

F. Emergency information

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:

Significant other/nearest friend or relative not residing with you: _____

G. Your education and training

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

H. Employment and military experiences

Dates	Name of employers	Job title or duties	Reason for leaving

I. Family-of-origin history

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

J. Significant romantic 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					

K. Children Indicate those from a previous relationship with "P" in the last column.

Name	Current age	Sex	School	Grade	Adjustment problems?	P?

L. Is there any other information you think we should know?

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