Jessica P. Harrell, Ph.D.
Licensed Clinical Psychologist
(248)767-5985
drjessicaharrell@gmail.com

CLIENT INFORMATION

Date:

NAME: ____

DATE OF BIRTH: ___________________

HOME ADDRESS: ____

____

Contact Information:

Primary Phone Number: ______________________________ cell/home/work (circle)

May I leave a message on this number? Yes/No (circle)

Secondary Phone Number: ______________________________ cell/home/work (circle)

May I leave a message on this number? Yes/No (circle)

Email Address: ____

*__Preferred method of communication__: PHONE/EMAIL (please circle one or both)

*Please note that the security of electronic communications can not be assured so the sharing of clinical information will be avoided and/or limited to the minimum amount of information necessary to meet the recipient's needs.

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Demographic Information:

Marital Status: Single ______ Married _______ Divorced _______Living Together _______ Widowed _______

Employment: Full-time ______ Part-time ______ Disabled ______ Homemaker ____

Employer: ____

Occupation: _______________________________ Length of employment: _______________________-

Education:

High School: ______ GED: ______ Some College: ______ Trade: ______ BA/BS: ______ Grad: _____

Are you a current student? ________ Full-time or part-time? ______________________

Please list all family members and persons living with you:

Name: ____________________________ Age: _____ Relationship to you: _____________

Name: ____________________________ Age: _____ Relationship to you: _____________

Name: ____________________________ Age: _____ Relationship to you: _____________

Name: ____________________________ Age: _____ Relationship to you: _____________

Name: ____________________________ Age: _____ Relationship to you: _____________

Medical History:

Current medical conditions: No _______ Yes (what/when) ___________________________

____

Surgeries/Serious accidents: No _______ Yes (what/when) ___________________________

____

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Are you currently being treated by a psychiatrist? No _______ Yes _______

Name of psychiatrist ______________________________ Phone _______________________

Please list all medications you are currently taking:

Medication: ______________________________________ Dosage: ____________________

Medication: ______________________________________ Dosage: ____________________

Medication: ______________________________________ Dosage: ____________________

Previous Psychological Treatment: None ________ Yes ________ (see below)

Outpatient Therapist: ______________________________________ Start/End Dates: ________________________

Reason for treatment: ____

Inpatient therapy (including substance abuse):

Where: ____ Start/End Dates: ________________________

Reason for admission: ____

Family History of Psychiatric Illness and/or Substance Abuse:

Mother: _______________________________ Father: ________________________________

Siblings: _______________________________ Other: ________________________________

Please explain your main concerns that brought you in today:

____

____

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