Birchtree Psychology
30 Sever Street
Worcester, MA 01609

Client Information Form

Today's date: _____

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

Identification:

Your name: _____

Date of birth: _____ Age: ____

Nicknames or aliases: _____

Home street address:
_____

Apt.: _____

City:
_____
_____

State: _____ Zip: _____

Home/evening phone: _____

Cell phone: _____

Work phone: _____

e-mail: _____

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

Is it okay for me to leave a message if I call you? ___yes ___no

Referral Information:

Name of person who referred you to me:

_____
___

Phone: _____

Address:

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

Racial / Ethnic / Religious Information:

Current religious denomination/affiliation:

❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu

Other (please specify):
_____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life?

Ethnicity/national origin: _____

Race: _____

Other way you identify yourself and consider important:

Employment:

Employer: _____

Address: _____

_____

Medical Information:

Clinic/doctor's name:
_____

Phone: _____

Address: _____

_____

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

Are you currently being treated for any medical conditions? If so, what are they?

Are you currently taking any medications? Please include dosages and frequency if you know them.

Have you gained or lost more than 10 pounds recently?

Are you comfortable with your current weight?

Previous Therapy Experience:

Have you ever been in therapy before?

If yes, when and with whom?

For what purpose?

With what results?

Presenting Concerns and Important History:

What brings you to my office today?

Do you currently drink or use any recreational drugs?
If so, how much and how often?

Do you have a history of:
(Please check all that apply)

__ Physical Abuse __ Sexual abuse __ Emotional abuse __ Financial abuse

__ Legal troubles __ Suicidal thoughts __Suicide attempts __ Attempts to harm

another person __ Eating disorders __ Cutting or other behavior that injures you

__ Hospitalization for mental health issues

Please elaborate on any of the items you checked. Use the reverse side of this form if you
need to.

Is there any other information you think I should know?

Is there anything else you'd particularly like me to ask you about when we talk?