FOR THIS OFFICE

# Charles R. Martin, Ph.D.

**Licensed Psychologist - Florida License PY5214**

**Client Information Form**

**PLEASE PRINT CLEARLY** **DATE _____**

## I. Demographic Information

_____ _____

Last Name First Name Middle Initial Birthdate

_____

Street Address Apt. #

_____

City State Zip Code

_____ Is it OK to call you at this number? Yes No

Phone Number (home/work/cell)

_____ Is it OK to call you at this number? Yes No

Phone Number (work/home/cell)

_____

Email address

Gender _____ Social security number _____

Race: Caucasian, African Descent, Hispanic/Latino/a, Asian/Pacific Islander, Native American, Multiracial_____, other_____

Are there other ways that you identify yourself? (i.e., religious affiliation, sexual orientation, cultural identity, or ability)_____

_____

Relationship status: Never married Living together Married
(circle those that apply) Divorced Widow/widower Separated

Living situation: Living alone Living w/ partner Living with roommate(s)
Living with parents Living with family

Work status: In school Employed part-time Employed full-time
Work caring for family Unemployed

Occupation or major in school_____

Referred by:_____

**II. Presenting Issues and Psychological History**

Briefly state your current concerns in your own words:_____
_____
_____

How much are these problems disrupting your life? A Little Somewhat Very Much

Have you been in counseling before? Yes No

If yes, please list with whom and approximate dates of treatment _____
_____

What was the focus of previous counseling?_____
_____

Have you ever been hospitalized for psychiatric reasons? Yes No
If yes, when_____ reason_____

List current medications and or physical/medical conditions: _____
_____

Name of primary physician_____ Phone Number_____

Have you ever seriously considered or attempted suicide? Yes No
If yes, when_____

Please circle if you have ever experienced:

| | |
|---|---|
| Sexual assault | Sexual molestation as a child |
| Physical abuse as a child | Emotional abuse as a child |
| Physical abuse by a partner | Emotional abuse by a partner |
| Incest | |

Please circle if you have ever had a problem with:

| | |
|---|---|
| Alcohol or drug abuse | Eating disorder |
| Depression | Anxiety |

Please circle if a member of your immediate family has ever had a problem with:

| | |
|---|---|
| Alcohol or drug abuse | Eating disorder |
| Depression | Anxiety |

Please describe current alcohol or non-prescription drug use _____
_____

**III. Family Information**

**Family of origin:**

Mother's marital status: Married Separated Divorced Widowed
Remarried Never Married Deceased Unknown

Father's marital status: Married Separated Divorced Widowed
Remarried Never Married Deceased Unknown

List names and ages of siblings: _____
_____

List any other important family members or caregivers and their relationship to you::_____

**Current family** (if applicable)

Circle all that apply:

Single Living with partner Divorced_____(year)
Married____(year) Separated_____(date) Widowed_____(year)
Other configuration _____

If you are in a relationship, partner's name _____
Age _____ Racial identification:_____
Gender_____ Occupation _____
Length of relationship _____

If you or your partner have children, list names and ages:_____
_____
_____

**I understand that I am responsible for payment of services rendered regardless of whether these services are covered by an insurance policy or not. I have been given and read a copy of Dr. Martin's statement of "*Policies and Practices to Protect the Privacy of Your Health Information.*"**

Signature: _____ Date: _____
(Client or guardian)