

Client Information Form

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Today's Date: _____

Personal Information

Name: _____ Age: _____ Gender: _____

Address: _____ Social Security #: _____

City, State, Zip: _____ Date of Birth: _____

Home Phone: _____ May I call this number? Y N May I leave a message? Y N

Cell Phone: _____ May I call this number? Y N May I leave a message? Y N

Person responsible for bill: _____ Relationship: _____

Address: _____ Phone: _____

Employer Information

Employer: _____ Occupation: _____

Address: _____

Work Phone: _____ May I call this number? Y N May I leave a message? Y N

Insurance Information

Primary Coverage

Name of Insured: _____ Social Security #: _____ DOB: _____

Insurance Company: _____

Address: _____ Phone: _____

Subscriber/ID #: _____ Group #: _____

Secondary Coverage

Name of Insured: _____ Social Security #: _____ DOB: _____

Insurance Company: _____

Address: _____ Phone: _____

Subscriber/ID #: _____ Group #: _____

Medical and Referral Information

Physician: _____ Phone: _____

Therapist/Counselor: _____ Phone: _____

Who referred you? _____ Relationship: _____

Current Household Information

Spouse/Partner Name: _____

Employer: _____ Work Phone: _____

Others in home (name):	Gender:	Age:	Relationship:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Emergency Contact Information

Emergency Contact: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

Legal Next of Kin: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

Family Information

	Living?	Age?	Illnesses/Cause of Death
Father:	Y N	_____	_____
Mother:	Y N	_____	_____
Brother / Sister:	Y N	_____	_____
Brother / Sister:	Y N	_____	_____
Son / Daughter:	Y N	_____	_____
Son / Daughter:	Y N	_____	_____
Partner (Male / Female):	Y N	_____	_____

Previous marriages:

Personal Medical History

Have you ever had or do you currently have any of the following (check all that apply):

- Head Injury with a Loss of Consciousness
- Seizure(s)
- Memory Lapses
- Neuroleptic Malignant Syndrome (NMS)
- Heart Attack or Heart Problems
- High Blood Pressure
- Toxic Reaction to Medications or Drugs
- Diabetes
- Asthma
- Allergies to Medication(s): _____
- Thyroid, Parathyroid, or Adrenal Problems
- Sexually Transmitted Diseases/HIV
- Constipation/Bowel Obstruction
- Difficulty Urinating
- Glaucoma
- Other medical problems (please explain): _____

Are you currently taking any medications? Y N (Please List) _____

Are You Pregnant? Y N Don't Know Last Menstrual Period _____

I HAVE READ AND ACCEPT THE INFORMED CONSENT TO TREATMENT FORM:

Signature Date

FOLLOW UP

I ask your permission to perhaps contact you from time to time even after the therapy is over to check in about your progress or to seek an opinion on the effectiveness of the work you did with me over time. I ask this to give me a way to monitor my effectiveness at my work. This in no way would be for the purpose of encouraging you back into therapy with me. If at any time you decide not to be contacted, I will respect this. If you are willing to allow this, please write your initials on the line below to give consent for this follow up.

_____ I consent to follow up contact