DEARDRE MCGUIRE, L.I.C.S.W., PLLC

~Psychotherapist~

Client Information Form

Today's Date: _____

A. DEMOGRAPHIC INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Nicknames/Aliases: _____ Social Security #: _____
Cultural/Ethnic Background/Religion: _____

Local Address: _____ Apt. #: _____

City: _____ State: _____ Zipcode: _____

Preferred phone: _____ Cell Home Work OK to leave msg? Y N

Secondary phone: _____ Cell Home Work OK to leave msg? Y N

Email: _____

Health Insurance Carrier: _____ Member ID#: _____

B. EMERGENCY CONTACT INFORMATION

Name: _____ Phone: _____

Relationship: _____

C. Health/MEDICAL CARE

Significant Medical History (including major illnesses, chronic conditions, accidents):

_____

_____

Doctor's/Clinic's Name: _____ Phone: _____
Current Psychiatrist: _____ Phone: _____
Current Psychiatric Medication: _____
Past Psychiatric Medication: _____
Other Current Medication: _____

If you enter treatment with me, may I tell your doctor(s) so that he or she can be fully informed and so that we can coordinate your treatment? Yes No

Previous Psychological Treatment (including any past hospitalizations):_____
_____
_____

D. PRIMARY CONCERN

Please describe your primary difficulties and concerns at this time.

_____
_____
_____

Please check all the items which are concerns at this time and circle those which are most important.

__ Abortion Issues	__ Drug use	__ Loneliness	__ Self-injury, mutilation
__ Abuse: emotional physical, verbal, sexual	__ Eating problems	__ Memory problems	__ Self-neglect, poor self-care
__ Academic issues	__ Emptiness	__ Mood swings	__ Sexual assault
__ Aggression/violent behavior	__ Family relationships	__ Motivation	__ Sexual concerns
__ Alcohol use	__ Fearing failure	__ Overly responsible to others	__ Sexual harassment
__ Anger, arguing	__ Fears, phobias	__ Overly sensitive to rejection	__ Sexual identity, Orientation
__ Anxiety, nervousness	__ Financial problems	__ Panic attacks	__ STDs
__ Body image	__ Gambling	__ Perfectionism	__ Shame
__ Career concerns, choices	__ Guilt	__ Peer relationship concerns	__ Shyness
__ Childhood issues	__ Harassment/stalking	__ Pregnancy	__ Smoking
__ Child/parent issues	__ Health, medical concerns	__ Prejudice/bias concerns	__ Sleep problems
__ Compulsive behaviors	__ Hallucinations	__ Procrastination/time mngt.	__ Stress
__ Computer excessiveness	__ Identity issues	__ Racial, ethnic concerns	__ Suicidal thoughts
__ Concentration	__ Impulsive, out of control	__ Repeated troubling thoughts	__ Tiredness, fatigue
__ Decision making, indecision	__ Independence from parents	__ Relationship concerns	__ Violent thoughts
__ Grief issues	__ Irresponsibility	__ Relationship violence	__ Withdrawal, isolation
__ Depression, sadness, crying	__ Learning disability	__ Religious/spiritual concerns	__ Worthless feeling
__ Divorce, separation	__ Legal problems	__ Romantic relationship issues	__ Other

E. REFERRAL INFORMATION: Who gave you my name to call?

Name: _____ Phone: _____

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

F. **EMPLOYMENT/EDUCATION**

Employer/University: _____
Your job description/Degree: _____

Agreement to Pay for Professional Services

I request that Deardre McGuire, L.I.C.S.W. provide professional services to me (or to my dependent named below) and I agree to pay Ms. McGuire's fee at the beginning of each session instead of being billed monthly.

I agree that this financial relationship will continue as long as Ms. McGuire provides services or until I inform her, in person or by certified mail, of my wish to terminate it. I agree to pay for services provided up until the time I terminate the relationship. Once I have decided to terminate psychotherapy, I agree to meet with Ms. McGuire at least one more time before ending therapy to discuss treatment and continuity of care.

_____ _____
Signature of client (or person acting for client) Date

_____ _____
Printed Name Name of Dependent if applicable

I, Deardre McGuire, have discussed the issues above with the client (and/or the person acting on the client's behalf). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature Date