

**MARINA BYSTRITSKY, Ph.D.**

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**Confidential Client Information**

Date of Initial Appointment \_\_\_\_\_

Client's Full Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone \_\_\_\_\_ Cell Number \_\_\_\_\_

Work Number \_\_\_\_\_ Email Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender F / M Social Security Number \_\_\_\_\_

**If client is an adult, please complete the following information:**

Marital Status \_\_\_\_\_ Spouse/Significant Other/Partner's Name \_\_\_\_\_

Occupation \_\_\_\_\_ Highest Level of Education \_\_\_\_\_

Do you have children? Y / N Names and Ages \_\_\_\_\_

**If client is a child, please complete the following information:**

Name of Parent(s) or Guardian(s) \_\_\_\_\_ Phone \_\_\_\_\_

Name of Noncustodial/Other Parent \_\_\_\_\_ Phone \_\_\_\_\_

Is the Other Parent/Guardian aware of and supportive of counseling? \_\_\_\_\_

Name of Siblings \_\_\_\_\_ Others in the House \_\_\_\_\_

Child's School and Grade Level \_\_\_\_\_

**Emergency Information**

Person to contact in case of emergency \_\_\_\_\_

Telephone number \_\_\_\_\_ Relationship \_\_\_\_\_

**Referral Source**

Who suggested you contact me? \_\_\_\_\_

If from another person, initial here \_\_\_\_\_ if it's ok for me to contact that person to thank them for their referral.

**Confidential Client Information, Page 2 – Client’s Name:** \_\_\_\_\_

**Medical History**

Physician’s name \_\_\_\_\_ Phone Number \_\_\_\_\_

Are you experiencing any health problem? Yes / No If yes, please describe \_\_\_\_\_

Are you taking Medication? Y / N If yes, please describe \_\_\_\_\_

**Counseling History**

Have you previously seen a counselor/therapist/psychologist/psychiatrist? \_\_\_\_\_

Briefly describe why you are seeking therapy: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have these concerns been causing you distress? \_\_\_\_\_

Please list anything else you feel that is important for us to know: \_\_\_\_\_

\_\_\_\_\_

**Please check any of the following difficulties that apply:**

Abuse/Neglect	Health Problems	Psychosis
Acting out Behaviors	Hyperactivity	Relationship Difficulties
Alcohol/Drug Use	Impulsivity	School problems/Poor Grades
Anger/Temper Issues	Insomnia/Sleep Difficulties	Self Control
Anxiety/Nervousness or Fears	Irritability	Sexual Problems/Sexuality Issues
Career Difficulties	Legal Issues	Shyness
Concentration Problems	Loneliness	Social Skills Deficits
Depression	Low Self Esteem	Stress
Divorce/Separation	Memory	Suicidal Thoughts or Actions
Domestic Violence	Nightmares	Tiredness
Eating Problems/Disorder	Odd Behavior	Thoughts of Hurting Others
Family Conflicts/Dysfunction	Panic	Trauma History
Financial Difficulties	Parenting Difficulties	Truancy
Gang Involvement	Promiscuity	Other: _____

**Preferred method of contact for appt reminders and other related correspondence (Circle One):**

Home Phone

Cell Phone

Work Phone