Hillside Psychology, P.L.L.C.
40 W. Main St. Mount Kisco, NY 10549
Tel: (914) 401-0215
email: hillsidepsych@gmail.com **website: hillsidepsych.com**

Client Information Form

Today's date: _____

A. Identification

Name: _____ Date of Birth: _____ Age: _____
Preferred Name: _____ Gender:_____
Home Street Address:_____
City:_____ State:_____ Zip Code: _____
Home Phone:_____ email: _____
Cell Phone: _____ I prefer to get calls ☐at home ☐on my cell
Calls or email will be discreet, but please indicate any restrictions:
_____

B. Referral: How did you come to find out about my services?

Name of person or of service: _____
Phone (if applicable): _____ Date Referred: _____
If a healthcare professional referred you, may I have your permission to thank this person for the referral? ☐Yes _____(please initial) ☐ No
How did this person explain how I might be of help to you?
_____

C. Emergency Information

If some kind of emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I call?
Name: _____ Phone: _____
Relationship:_____

D. Your Medical Care: From whom or where do you get your medical care?

Clinic/Doctor's Name: _____ Phone:_____
Date of last physical/medical exam: _____

If you enter treatment with me, would you like me to contact your medical doctor so the they can be fully informed and we can coordinate your treatment? ☐ Yes (you will need to complete the Authorization to Release Information Form) ☐No

E. Your Current Employer

☐ Not currently employed
Employer: _____ Occupation: _____
Work Phone: _____ or other means of communication _____

Communication will be discreet, but please indicate any restrictions:
_____

F. Educational History

Highest level of education completed: _____
Name of School and City: _____

Did you ever have any significant educational concerns or support, such as reading support, speech/language, repeat or skip a grade, or receive gifted services?
If so, please describe:
_____
_____

G. Ethnic and Cultural Identification

Ethnicity/National Origin: _____
or other similar way you identify yourself and consider important:
_____

Current religious denomination/affiliation ☐ None ☐Atheist/Agnostic ☐Buddhist ☐ Catholic ☐Christian ☐Hindu ☐Islamic ☐Jewish ☐LDS ☐Other (Specify):
_____

H. Other Identifying Information

Relationship Status: ☐Single ☐Partnered ☐Domestic Partner ☐Married ☐Separated ☐ Divorced ☐ Widowed ☐Other (Specify):_____

Sexual Orientation: ☐Bisexual ☐Heterosexual ☐Gay ☐Lesbian ☐Queer ☐Questioning ☐Other (Specify): _____

I. Presenting Concern

Please describe the main difficulty that has brought you to see me:
_____
_____
_____

Adult Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom of under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

☐ I have no problem or concern
☐ Abuse of other – physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
☐ Victim of Abuse – physical, sexual, emotion, neglect
☐ Aggression, violence
☐ Alcohol use
☐ Anger, hostility, arguing, irritability
☐ Anxiety, nervousness
☐ Attention, concentration, distractibility
☐ Career concerns, goals, and choices
☐ Childhood issues (your own childhood)
☐ Codependence
☐ Compulsions
☐ Custody of children
☐ Decision making, indecision, mixed feelings, putting off decisions
☐ Delusions (false ideas)
☐ Dependence
☐ Depression, low mood, sadness, crying
☐ Divorce, separation
☐ Drug use – prescription medication, over-the-counter medications, street drugs
☐ Eating problems – overeating, undereating, appetite, vomiting (see also "Weight and diet issues)
☐ Emptiness
☐ Failure
☐ Fatigue, tiredness, low energy
☐ Fears, phobias
☐ Financial or money troubles, debt, impulsive spending, low income
☐ Friendships
☐ Gambling
☐ Grieving, mourning, deaths, losses, divorce
☐ Guilt
☐ Headaches, other kinds of pains
☐ Health, illness, medical concerns, physical problems
☐ Inferiority feelings
☐ Impulsiveness, loss of control, outbursts
☐ Irresponsibility
☐ Judgment problems, risk taking
☐ Legal matters, charges, suits
☐ Loneliness
☐ Memory problems
☐ Menstrual problem, PMS, Menopause
☐ Mood swings
☐ Motivation, laziness
☐ Nervousness, tension
☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
☐Oversensitivity to rejection
☐Pain, chronic
☐Panic or anxiety attacks
☐Parenting, child management, single parenthood
☐Perfectionism
☐Pessimism
☐Procrastination, work inhibitions, low motivation
☐Relationship problems (with friends, with relatives, or at work)
☐Relationship problems (romantic) conflict, distance/coldness, infidelity/affairs, different expectations, disappointments
☐School problems
☐Self-centeredness
☐Self-esteem
☐Self-neglect, poor self-care
☐Sexual issues, dysfunctions, addiction, conflicts, desire differences
☐Shyness, oversensitivity to criticism
☐ Sleep problems – too much, too little, insomnia, nightmares

☐ Smoking and tobacco use
☐ Spiritual , religious, more, ethical issues
☐ Stress, relaxation, stress management, stress disorders, tension
☐ Suspiciousness, distrust
☐ Suicidal thoughts
☐ Temper problems, self-control, low frustration tolerance
☐ Thought disorganization and confusion
☐ Threats, violence, thoughts of harming others
☐Weight and diet issues
☐ Withdrawal, isolation
☐Work problems, employment, workaholism/overworking, difficulty keeping a job, dissatisfaction
☐Other:
_____
_____
_____