Kathleen Nickerson, PhD
Licensed Clinical Psychologist – PSY 20446
280 Newport Center Drive, Suite 200, Newport Beach, CA 92660

Client Information Sheet

Name: ______________________________________ Date: ________________________________
Address: ____________________________________ Home Phone: _________________________
City/Zip: _____________________________________ Work Phone: _________________________
Email: _______________________________________ Cell Phone: __________________________

Date of Birth: __________________ Age: __________ SS#:_________________________________
Race: _________________________ Sex: __________ DL#:_________________________________
Marital Status: _________________ Spouse/Partner Name: ___________________________________
Children: Names/Ages: ____

Occupation: ______________________________ Employer: ___________________________________
Education: _______________________________ Hobbies: ____________________________________

Reason for seeking therapy now: ____
____
____

How would you rate your relationship with your:

Spouse or Partner:	□ Excellent	□ Good	□ Fair	□ Poor
Child/Children:	□ Excellent	□ Good	□ Fair	□ Poor
Mother:	□ Excellent	□ Good	□ Fair	□ Poor
Father:	□ Excellent	□ Good	□ Fair	□ Poor
Siblings:	□ Excellent	□ Good	□ Fair	□ Poor

Previous Therapy: □ Yes □ No When? __________________ How long? _______________
Reason for seeking treatment at that time: ____

Primary Physician: _________________________ Contact Number: ______________________________
Psychiatrist: ______________________________ Contact Number: ______________________________

Do you drink alcohol?	□ Yes	□ No	How much? ____________	How often? ________________
Do you drink caffeine?	□ Yes	□ No	How much? ____________	How often? ________________
Do you smoke cigarettes?	□ Yes	□ No	How much? ____________	How often? ________________
Do you use narcotics?	□ Yes	□ No	How much? ____________	How often? ________________
Do you take steroids?	□ Yes	□ No	How much? ____________	How often? ________________

Current Medications: ____
Current Vitamins/Supplements: ____
Current Illnesses: ____
Family History of Mental Illness: ____
Past or Current Legal Difficulties: ____

In case of emergency, please contact:____
Home: ______________________ Work: ___________________________ Cell: ______________________

Printed Name: _________________________ Signature: _____________________________________