James Hopper, Ph.D.

CONFIDENTIAL CLIENT PERSONAL INFORMATION SUMMARY

Today's Date:_____

Ms./Mr./Mrs./Dr._____

Street_____City/State_____Zip_____

Telephone (h)_____ (w) _____

Age_____Birth date_____Birthplace_____

By whom were you referred?_____

Relationship to you?_____

If any part of your fee is to be paid by insurance, please list the following information:

Group ( ) Individual ( )

Insurance Company_____Policy #_____

MARITAL STATUS:

Single ( ) Married ( ) Partnered ( ) Widowed ( ) Divorced ( )

Currently married? Yes ( ) No ( ) When?_____
Separated/divorced? Yes ( ) No ( ) When?_____

I married previously, please list dates of prior marriages, how terminated, and number of children from each marriage, who has the custody of those children now:

_____

_____

_____

_____

_____

IMPORTANT PEOPLE IN YOUR LIFE:

Name	Sex	Age	Grade/Job	Living with You?

What problems bring you here? _____

_____

_____

_____

Have any of the following problems affected you, or a member of your family?
(Please check those that apply)

When? How long? Who?

( ) School _____
( ) Work _____
( ) Living situation _____
( ) Eating problems _____
( ) Alcoholism _____
( ) Other substance abuse problems _____
( ) Sexual assault/abuse _____
( ) Physical abuse _____
( ) Emotional abuse/neglect _____
( ) Other traumatic experiences _____
( ) Mental illness _____
( ) Hospitalization-mental _____
( ) Hospitalization-physical _____
( ) Legal problems _____
( ) Medical/physical problems _____
( ) Other problems:

_____ _____

_____ _____

MEDICAL HISTORY

Primary Care Physician: _____

Address: _____

_____

Phone Number: _____

Date of Last Visit: _____

Number of Visits Last Year: _____

Current Medications: _____

_____

_____

(If different than primary care physician):

Prescribing Physician: _____

Address: _____

_____

Phone Number: _____

Date of Last Visit: _____

Have you been in therapy before? ( ) No ( )Yes

If yes, with whom? _____

When? _____ To _____

Why did you seek therapy? _____

_____

Was it helpful? _____

Names of other therapists/treaters Dates of Treatment:

_____ _____

_____ _____

_____ _____

Have you ever been hospitalized? ( ) No ( ) Yes

If yes, where? _____

When? _____ To _____

Why? _____

Other hospitalizations:

Hospital: Dates of Hospitalization:

_____ _____

_____ _____

SOCIAL SUPPORTS/RESOURCES:

Please check the social supports you currently have:

( ) Social services
( ) Friends
( ) Faith/spiritual community
( ) After school activities
( ) Regular exercise
( ) Fine arts/performing arts activities
( ) Hobbies
( ) Sports (organized events/teams)
( ) Other sources of support and/or comments on those checked above:

_____

_____

_____

_____

_____