SYLVAN PSYCHOLOGICAL, PLLC

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New Client Information Form

Contact Information

Name (First, Last, MI): _____

Legal Name (if different from given name): _____

Address: _____ *City:* _____

State: ____ *Zip Code:* _____

Phone: _____ May I call this number? ☐ Y ☐ N

May I leave a message at this number? ☐ Y ☐ N

If I do not have permission to leave a message with you, please list days and times in which I can get a hold of you:

_____

_____

May I contact you via text? (scheduling or administrative communications only): ☐ Y ☐ N

Email Address: _____

May I contact you at this address (scheduling or administrative communications only): ☐ Y ☐ N

Emergency Contact Name: _____ *Relationship:* _____

Emergency Contact Phone Number: _____

Personal Information

Age: _____ *Date of Birth: _____*

Identified Gender:

☐ Man ☐ Woman ☐ Non-Binary ☐ Genderqueer ☐ Agender

☐ My gender identity is not listed (please specify): _____

Do you identify as transgender, or hold a gender identity other than the one you were assigned at birth?

☐ Yes ☐ No

Pronouns (please select all that apply):

☐ She/Her ☐ He/Him ☐ They/Them
My pronouns are not listed (please specify): _____

Relationship Status: _____

Have you ever been married? ☐ No ☐ Yes # of times: _____

Have you ever been divorced? ☐ No ☐ Yes # of times: _____

If you have children or dependents, how many? ____

Highest level of education?

☐ Grade school ☐ Some college

☐ Middle school ☐ Associate's degree

☐ Some high school ☐ Bachelor's degree

☐ High school degree/GED ☐ Master's degree

☐ Trade school degree ☐ Doctoral or professional degree

Are you employed? ☐ Yes ☐ No

Employer: _____ *Job Title/Position:* _____

Hrs/Week: _____

Income (annual or monthly): _____

Are you a student? ☐ Part-time ☐ Full-time *Credit hours this semester:* _____

What is your student status:

☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate Student

Major or Degree Program: _____

Current Number of Years Working on this Degree: _____

Personal Identities

Racial identity (check all that apply):

☐ Asian/Asian-American

☐ Black/African-American

☐ Latinx/Latina/Latino

☐ First Nations/Native American (please specify tribe): _____

☐ Pacific Islander

☐ White/European-American

☐ Biracial/Multiracial (please check all relevant racial identities)

☐ My racial identity is not listed (please specify): _____

Sexual Orientation:

☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Queer ☐ Pansexual ☐ Asexual

☐ My sexual orientation is not listed (please specify): _____

National Identity:

☐ United States

☐ I am a first-generation US-citizen; my family's country of origin is: _____

☐ I hold a different national identity (please specify): _____

Ethnic and Cultural Identities:

Please list any cultural or ethnic identities that are important to you: _____

_____

Religious/Spiritual Identity:

Please list any religious or spiritual identities that are important to you: _____

_____

Medical Background

Primary Care Physician: _____ *Phone:* _____

Fax: _____

Please list any significant medical conditions, including past and current conditions:

_____

_____

_____

Please list all medications (including supplements), your dosage, and how often you take them:

_____

_____

_____

_____

_____

Do you have a history of head injuries or concussions? ☐ Yes ☐ No

If yes, please explain: _____

_____

How often do you consume alcoholic beverages (daily, weekly, monthly, etc.)?

_____

When you drink, how many alcoholic beverages do you typically consume? One standard drink is 12 oz. regular beer [5% ABV], 5 oz. wine [12% ABV], or 1.5 oz. distilled spirits [40% ABV].

_____

_____

Do you use marijuana? ☐ Yes ☐ No

Please specify amount and frequency: _____

Do you use other substances? ☐ Yes ☐ No

Please specify what substance(s), amount, and frequency: _____

_____

_____

Mental Health History

Have you been in psychotherapy/counseling before? ☐ Yes ☐ No
Please list providers and approximate dates you attended: _____

_____

_____

Would you like me to contact your past providers to request records? ☐ Yes ☐ No

Please list any past or present mental health conditions: _____

_____

_____

Have you ever been in inpatient/psychiatric hospitalization? ☐ Yes ☐ No
Please specify reasons and approximate dates: _____

_____

Referral Information

How did you find out about Sylvan Psychological? _____

_____

Automated Appointment Reminders

Please specify how you would like to receive appointment reminders (please select ONE option only)

☐ Via text message to cell phone number: _____

☐ Via email message to the following email address: _____

☐ Via automated phone message to the following number: _____

☐ I do not wish to receive appointment reminders and will be responsible for remembering my own appointment days and times.

Please note: Due to technical issues with my billing and clinical note software, I am unable to offer automated appointment reminders to clients using OON benefits or self-pay. Sorry for any inconvenience.