Margaret Reedy, Ph.D.
15615 Alton Parkway, Suite 220
Irvine, California 92651
(949) 727–1838

Date: _____

Client Information

Full Name: _____
first middle last

Address: _____
number street city state zip

Home Phone: ( ) _____ Business Phone: ( ) _____

Cell Phone: ( ) _____ email address: _____

Birthdate: _____ Age: _____ Social Security #: _____

Occupation/Job Title: _____ Employer: _____

Employment Address: _____

If you are a student, please indicate your school and year or grade: _____

Spouse/Partner/Parent Information

Name: _____ Years Married: _____

Birthdate: _____ Age: _____ Social Security #: _____

Occupation/Job Title: _____ Employer: _____

Employment Address: _____

Payment for services is due each visit and any charges incurred due to collection or attorney's fees become the responsibility of the client. Sessions must be canceled with at least 24 hours notice. Failure to provide 24 hours notice will result in your being charged for the missed session. All written or spoken material from any and all sessions, including psychological testing, will be considered confidential unless you give written permission to release all or part of this information to a specified person, persons, or agency. Exceptions to this confidentiality involve cases where the law requires a licensed therapist to report instances where a child has been abused or sexually molested and/or where there is an eminent danger to self and others. In addition, it is understood that cases are sometimes discussed by the professional staff in order to obtain feedback and provide alternative treatment plans to the procedures being considered and/or being used.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE CONDITIONS.

Signature _____ Date _____

Person To Notify In Case of Emergency (Other Than Spouse)

Name: _____ Relationship to You: _____

Address: _____ Phone: ( ) _____

Current Symptoms/Problem and Background Information

Briefly describe reason for seeking help: _____

_____

Approximate date these problems/symptoms first appeared: _____

Have you ever had these problems/symptoms before? Yes No If Yes, when? _____

Name of your physician and approximate date of last visit? _____

Reason for visit? _____

List current health problems: _____

_____

Family Information

List the members of your family and all others living with you at this time:

Name	Age	Relationship	Occupation

Prior Marriages

Please list prior spouse's names and marriage dates for yourself and/or for your spouse/partner:

_____

_____

List parents, step parents, siblings and any children of yours and/or your spouse who do not live with you:

Name	Age	Relationship	Occupation

Prior History of Psychological/Psychiatric Treatment or Treatment for Alcohol or Drug Problems

Dates Problem Outpt/Inpt Name of MD/Therapist

_____

_____

_____

If you drink alcoholic beverages, please indicate which kind and how often:

_____

If you use drugs of any kind, including prescription medications and/or street drugs, please indicate which kind, for what purpose, the dosage/amount and frequency:

Drug Purpose Dosage/Frequency

_____

_____

_____

Names and relationship to you of family members in which there has been a drinking or drug problem (include grandparents, significant aunts or uncles):

_____

_____

Have you or has anyone in your family had an eating problem (e.g. overeating, anorexia, bulimia)?

Yes No

If yes, who? _____

Have you been a victim of physical, sexual or emotional abuse or neglect?

Yes No

If yes, by whom? _____

Do you currently have any legal problems?

Yes No

If yes, please describe: _____

_____

_____

Symptom Checklist

Please circle any of the following problems which apply to you:

Nervousness	Depression	Fears	Shyness
Sexual Problems	Suicidal Thoughts	Separation	Divorce
Finances	Drug Use	Alcohol Use	Friends
Anger	Self Control	Unhappiness	Sleep
Stress	Work	Relaxation	Headaches
Tiredness	Legal Matters	Memory	Ambition
Energy	Insomnia	Making Decisions	Loneliness
Concentration	Health Problems	School	Career Choices
Marriage Problems	Temper	Nightmares	Appetite
Stomach Trouble	Bowel Troubles	Being a Parent	My thoughts
Children	Inferiority Feelings	My parents	Education
Self Confidence	Anxiety	Aging	Guilt

Thank you for your time and attention in completing this information form.