Jaelline Jaffe, Ph.D.
4910 Van Nuys Blvd, Suite 111, Sherman Oaks, CA 91403

CONFIDENTIAL CLIENT INFORMATION FORM -- ADULT
PLEASE USE BLACK OR BLUE INK

GENERAL INFORMATION

Today's Date _____

Client's Name _____ I found you via referral from: _____

Google or other search _____ Internet: referral site (which): _____

Address _____City/State _____ Zip _____ Home Phone ( ) _____

Cell phone ( ) _____ e-mail address: _____

Birthdate _____ Age ____ Gender Identity _____ Pronouns used _____ Education highest level _____

Driver's License # _____ Car Make _____ Lic. # _____

Preferred Counseling Setting ___ In Person (Sherman Oaks) ____ Telehealth (video format) ____ Either

EMPLOYMENT

Occupation _____ Work Responsibilities _____ Work phone ( ) _____

Employer _____ Address_____ City/State _____Zip _____

PERSONAL / FAMILY INFORMATION

Marital Status _____ If married, anniversary date _____

Partner's Name _____ Partner's Age _____ Partner's Occupation _____

Length of current marriage/relationship _____ Names/ages of children (this marriage) _____

Previous marriage(s) ____ Length of each _____Names/ages of children (previous marriage(s) _____

Legal/physical custody? visitation arrangement? _____

Emergency Contact, if those in house cannot be reached:

Name _____ Relationship _____ Phone ( ) _____ Cell ( ) _____

Purpose for today's consultation: _____

Are you CURRENTLY involved in a legal procedure? _____ If so, does it concern your seeking counseling? _____

FINANCIAL INFORMATION

Preferred Payment: ___ Cash ___ Check (in person only) ___ PayPal ___ Credit Card

Credit Card Authorization (*separate form*) (Credit Card Billing will appear as THERAPY PARTNER)

I will need claim form for insurance reimbursement (in CA only) ___ YES ___ NO

OVER

<u>CONFIDENTIAL</u> PSYCHOLOGICAL/MEDICAL HISTORY

Are you CURRENTLY seeing another psychotherapist or counselor? _____ If so:

Name _____ Phone ( ) _____

For how long? _____ For what purpose(s)? _____

Have you PREVIOUSLY been in psychotherapy or counseling? _____ If so: When? _____

For how long? _____ For what purpose(s)? _____ Results _____

If you have had difficulties with any of the following, please explain:

_____ Alcohol, drug, or tobacco dependence or frequent use? _____

_____ Eating disorder(s)? _____

_____ Other addictive or compulsive behavior(s)? _____

_____ Depression or suicidal thoughts? _____

_____ Anxiety or panic attacks? _____

_____ Major illness, surgery, or other physical problems (including perimenopause)? _____

_____ Anger, arguments, domestic violence (current or childhood)? _____

_____ Marital, relationship, or family (current or childhood)? _____

_____ Learning disabilities/problems or ADD/ADHD? _____

List stressful situations in your life (accident, hospitalization, separation fm loved ones, traumatic event, head injury, etc.)

_____

_____

What have you found has been helpful to you when you have felt depressed, anxious, etc.?

_____

In ONE word, please describe your current: relationship situation _____ sexual relationship(s) _____

Please list ALL prescription medications you are CURRENTLY taking:

_____

Please list any PREVIOUS medications you have taken for psychological purposes:

_____

Amount of CURRENT use: Tobacco/Vaping _____ Alcohol _____ Caffeine (coffee/cola/chocolate) _____

Sugar _____ Other drugs (marijuana, cocaine, etc - specify) _____

Date of last medical exam _____ Doctor's Name _____ Phone ( )_____

Other useful information to assist in counseling: _____