ERIC L. STRANG, PSY.D.
CLINICAL PSYCHOLOGIST
PHONE: (310) 450-2301 LICENSE # PSY 17729

Client Information Form

Today's date: _____

A. Identification

Childs name: _____ Date of birth: _____ Age: _____

Your nicknames or aliases: _____ Social Security #: _____

Mothers name: _____ Father's name: _____

Home street address: _____ Apt.:_____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Calls will be discreet, but please indicate any restrictions:_____

_____

B. Parent's current employer

Employer: _____

Address : _____Suite:_____

City: _____ State: _____ Zip: _____

Work phone: _____ Calls will be discreet, but please indicate any restrictions: _____

_____

C. Chief concern
Please describe the main difficulty that has brought you to see me: _____

_____

_____

_____

_____

_____

_____

Cont.

D. Treatment

1.Has your child ever received psychological or psychiatric or counseling services before? ☐No ☐Yes If yes, please indicate:

When?	From whom?	For what?	With what results?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2.Has your child taken medications for psychiatric or emotional problems? ☐No ☐Yes If yes, please indicate:

When?	From whom?	Which medications	For what	With what results?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

E. Legal history

1. Are you presently suing anyone or thinking of suing anyone? ☐No ☐Yes If yes, please explain:

_____

_____

2. Is your reason for coming to see me related to an accident or injury? ☐No ☐Yes If yes, please explain:

_____

_____

3. Are you required by a court, the police, or a probation/parole officer to have this appointment?

☐No ☐Yes If yes, please explain: _____

_____

_____

4. Are there any other legal involvements I should know about? _____

_____

_____

Your signature below indicates that the above information is true and correct to the best of your knowledge.

_____ _____

Signature of Parent Date

_____ _____

Signature of Child Date