CLIENT INFORMATION FORM

NAME_____ Home Phone_____
Email_____ Mobile Phone_____
Home Address_____ City_____ State___ Zip_____
Parent/Spouse/Partner'sName_____Phone _____
Whom may I contact in case of emergency? _____Phone _____
Whom may we thank for referring you? _____
Date of Birth _____Age _____ Occupation _____
Physician _____ Phone_____
Who is financially responsible for the bill? _____
I will be paying today by CASH _____CHECK_____VISA/MC/AMEXP_____
List any **MAJOR** health problems for which you currently receive treatment or have been treated

_____
List any **MEDICATIONS** you are presently taking: _____
_____
Have you received counseling of any kind before? ____IF YES, PLEASE EXPLAIN _____-
_____
WHAT ARE YOU INTERESTS AND HOBBIES? _____
_____
LIST MEMBERS OF YOU FAMILY INCLUDING YOURSELF AND ALL OTHERS IN YOUR HOME
NAME AGE RELATIONSHIP OCCUPATION

_____
_____
_____
_____
_____

LIST MEMBERS OF YOUR FAMILY WHO LIVE OUTSIDE YOUR HOME
NAME AGE RELATIONSHIP OCCUPATION

_____
_____
Presenting Problem/**WHY ARE YOU HERE TODAY?**
_____
TOP FIVE NEGATIVE MEMORIES _____
_____

Please circle any of these other problems that you have:

Nervousness Inferiority Drug Use Suicidal Thoughts Gambling Substance Use
Shyness Depression Fears Friends Memory Focus Alcohol Anxiety Psychedelics
Separation Sexual Issues Unhappiness Ambition Temper Appetite Hormones
Marriage Health Issues Anger Attention Sleep Energy Snoring
Parenting Headaches Concentration Memory Focus Nightmares Insomnia
Stress Relaxation Tiredness Worry Obsessions Compulsions Habits
Panic Rituals Suspiciousness Learning Career School Work Other

I have read all the information on this client information form. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or any changes in the above information.
I will notify you at least 24 hours before a scheduled appointment if I need to cancel or I will pay for the session. I authorize Dr.Robert LoPresti to provide psychological and/or consultation services to me.
NJ, HIPPA, and Dr LoPresti's policies and procedures are available to me.

_____**Date**_____
SIGNATURE (PARENT IF MINOR)