

Robert LoPresti, Ph.D.
CLIENT INFORMATION FORM

Name _____ Home Phone _____ Work Phone _____

Home Address _____ City _____ State _____ Zip _____

Parent/Spouse's Name _____ Work Phone _____

Whom may we contact in case of emergency? _____ Phone _____

Whom may we thank for referring you to us? _____ Phone _____

Date of Birth _____ Age _____ Occupation _____ Social Security # _____

Physician _____ Address _____ Phone _____

Who is financially responsible for this bill? _____ Phone _____

I will be paying today by **CASH** _____ **CHECK** _____ **VISA/MC** _____

List any **MAJOR** health problems for which you currently receive treatment or have been treated for _____

List any **MEDICATIONS** you are presently taking _____

Have you ever received counseling of any kind before? _____ If so please explain _____

What are your interests and hobbies? _____

LIST MEMBERS OF YOUR FAMILY INCLUDING YOURSELF AND ALL OTHERS IN YOUR HOME Name

Age Relationship Occupation

List any members of your family living outside your home:

Name	Age	Relationship	Occupation

PREXSENTING PROBLEM: _____

TOP FIVE NEGATIVE MEMORIES: _____

Please circle any of the other problems which pertain to you:

- | | | | | | | |
|-------------|----------------------|------------------|-------------------|--------------|----------------|-------------|
| Nervousness | Inferiority Feelings | Making Decisions | Suicidal thoughts | Gambling | Substance Use | Alcohol |
| Shyness | Depression | Fears | Friends | Work | Memory | Focus |
| Separation | Sexual Problems | Unhappiness | Ambition | Temper | Appetite | Other |
| Marriage | Health Problems | Anger | Loneliness | Sleep | Energy | Hormones |
| Parenting | Drug use | Headaches | Concentration | Habits | Nightmares | Snoring |
| Stress | Relaxation | Tiredness | Attention | <i>Worry</i> | Obsessions | Compulsions |
| Panic | Rituals | School | Learning | Career | Suspiciousness | Paranoid |

I have read all the information on this sheet and have completed the above answers. 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 the above information. I will notify you at least 24 hours before I cancel an appointment, or I will pay for the session. I authorize Dr. Robert LoPresti to provide

psychological and/or consultation services to me; NJ HIPPA and Policy/Procedures are available to me.

_____ Date _____

SIGNATURE (Parent if Minor)