LOU A. LICHTI, Ph.D. | CITY PARK PSYCHOLOGICAL SERVICES, LLC

Name of Client: _____
Last First Middle Name you wish to be called by

Age: ____ Date of Birth: _____/____/_____ Telephone: Cell: _____ Other: _____
Month /Day /Year

Address: _____ Email: _____
Street/P O Box

_____ Gender: ____Male ___ Female
City State Zip

Referred By: _____ Today's Date: ____/____/_____
Name Relationship Month/Day/Year

Relationship Status: ___Single ___Married ___Divorced ___Separated ___Widowed ___Significant Other

Occupation: _____ Employed By: _____

Emergency Contact Name and Telephone: _____

Family Information:	**Name**	**Age**	**Occupation**	**Deceased Date**	**Education**	**Health Status**
Father:	_____	_____	_____	___/___/____	_____	_____
Mother:	_____	_____	_____	___/___/____	_____	_____
Step-Father:	_____	_____	_____	___/___/____	_____	_____
Step-Mother:	_____	_____	_____	___/___/____	_____	_____
Brothers/Sisters: (circle gender)						
M F	_____	_____	_____	___/___/____.	_____	_____
M F	_____	_____	_____	___/___/____.	_____	_____
M F	_____	_____	_____	___/___/____.	_____	_____
M F	_____	_____	_____	___/___/____.	_____	_____
M F	_____	_____	_____	___/___/____.	_____	_____
M F	_____	_____	_____	___/___/____.	_____	_____
Spouse/Partner:						
M F	_____	_____	_____	___/___/____.	_____	_____
Sons/Daughters:						
M F	_____	_____	_____	___/___/____.	_____	_____
M F	_____	_____	_____	___/___/____.	_____	_____
M F	_____	_____	_____	___/___/____.	_____	_____
M F	_____	_____	_____	___/___/____.	_____	_____
M F	_____	_____	_____	___/___/____.	_____	_____

Education/Training/Work Experience: _____
_____
_____
_____(Please complete next page)

Health:

Describe your health_____
_____
_____

What medication, if any are you currently taking?

Name	**Dosage**	**Condition**

Date of last physical exam: ___/___/____ Name of physician: _____Telephone No: _____

Address:_____
Street City State Zip

Please note any noteworthy physical problems: _____
_____
_____

Brief (1-2 Sentences) description of problem for which you are seeking help: _____
_____
_____
_____
_____
_____
_____

Previous Psychotherapy/Counseling/Psychological Assessment:

Therapist Name: _____ Telephone Number: _____ ___ Individual ___Family ___Couples
(Mark all that apply)

Address: _____
Street City State Zip

Duration of Treatment: From: ___/___/____ to ___/___/____ Session Frequency: ____ Weekly Monthly (circle one)

Outcome and helpfulness: _____
_____

Previous Psychotherapy/Counseling/Psychological Assessment:

Therapist Name: _____ Telephone Number: _____ ___ Individual ___Family ___Couples
(Mark all that apply)

Address: _____
Street City State Zip

Duration of Treatment: From: ___/___/____ to ___/___/____ Session Frequency: ____ Weekly Monthly (circle one)

Outcome and helpfulness: _____
_____

Special Interests/Hobbies: _____
_____
_____
_____
_____
_____