LICENSED OKLAHOMA STATE
BOARD OF EXAMINERS
OF PSYCHOLOGISTS

CLINICAL PSYCHOLOGY

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CLIENT INFORMATION QUESTIONNAIRE

NAME: _____ Today's Date: _____

Age: _____ Birthdate: _____ Gender: Male Female

Address: _____ Home Phone : (___) _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Cell or Pager: _____

Employer: _____ Business Phone: (___) _____

Address: _____ City: _____ State: _____

Education: _____ SSN: _____

Marital Status: Single Married Divorced Separated Widowed

Date of Present Marriage: _____

Spouse's Name: _____ Age: _____ Date of Birth: _____

Occupation: _____ SSN: _____

Employer: _____ Address: _____

Zip Code: _____ Business Phone: (___) _____

Spouse's Education: _____

CHILDREN:

Name	Age	Living at Home?

Dates of Previous Marriages: _____ to: _____

_____ to: _____

(Go to next page, please...)

Name of person, other than spouse, to contact in case of an Emergency:

_____

Address: _____

Phone: _____

Who Referred You Here? _____

Briefly Describe Your Reason For Seeking Help: _____

_____

_____

When Did These Problems First Begin? _____

Have You Ever Received Psychological or Psychiatric Help of Any Kind Before? _____

If Yes, Please List the Name of the Professional and the Dates: _____

_____

List Any Major Health Problems for Which You Are Currently, or Have Recently, Received Treatment:

_____

_____

_____

List All Medications You Are Now Taking and the Dosage: _____

_____

_____

Do You Plan To Use Insurance To Cover a Portion of Your Treatment Here? _____

If So, Please Complete the Following:

Name of Insurance Company: _____

Name Insurance Coverage Is In: _____

ID Number: _____

Group or Policy Number: _____

_____

Signature of Person Responsible for Payment

(Go to next page, please…)

Please Circle Any of the Following Problems Which Pertain to You.

NERVOUSNESS	DEPRESSION	FEARS
SHYNESS	SEXUAL PROBLEMS	SUICIDAL THOUGHTS
SEPARATION	DIVORCE	FINANCES
DRUG USE	ALCOHOL USE	FRIENDS
ANGER	SELF-CONTROL	UNHAPPINESS
SLEEP	STRESS	WORK
RELAXATION	HEADACHES	TIREDNESS
NATURAL DISASTERS	MEMORY	AMBITION
LEGAL MATTERS	LEARNING DISABILITY	BOYFRIEND/GIRLFRIEND
SCHOOL	INSOMNIA	MAKING DECISIONS
ENERGY	INFERIORITY FEELINGS	CONCENTRATION
LONELINESS	CAREER CHOICES	HEALTH PROBLEMS
EDUCATION	NIGHTMARES	MARRIAGE
TEMPER	APPETITE	STOMACH TROUBLES
CHILDREN	BEING A PARENT	DISTURBING THOUGHTS
BOWEL TROUBLES	TENSION	ANXIETY
MOODINESS	UNUSUAL EXPERIENCES	CONFUSION
EXCESSIVE WORRY	CHILD ABUSE	DEATH
FAMILY	IRRITABILITY	BOREDOM

Thank You For Completing This Questionnaire.