Psychological Services of South Florida
1640 Town Center Circle, Suite 204
Weston, FL 33326
(954) 804-5144

Client Information

Please complete these forms in as much detail as possible. Please print.

Date:_____

Name: _____, _____
Last First

Address: _____
Street

_____
City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____
Ok to call? Y N Ok to call? Y N Ok to call? Y N
Ok to leave message? Y N Ok to leave message? Y N Ok to leave message? Y N

Age_____ Date of Birth_____ Place of Birth_____

Social Security #_____

Employer: _____

Whom may I thank for referring you? _____

City:_____ State:_____ Zip_____ Phone#_____

Have you had prior counseling? If so, When? _____

Where? _____

Chief Complaint? _____

_____

_____

_____

Medical Information

Do you have a regular physician? ( ) no ( ) yes

Name_____ Location_____

Please list any serious medical conditions:_____

_____

Are you currently taking any medications? ( ) no ( ) yes Please list:_____

_____

Please list any previous hospitalizations (dates and reasons): _____

_____

Please describe your current use of alcohol and/or non-prescription drugs? (what, how often, how much): _____

_____

Spouse/Family Information

Spouse Name:_____

Date of Birth: _____/_____/_____/ Social Security #_____

Work Phone# _____

Parent (s) Name (s):

Mother: _____ Work Phone#_____

Date of Birth: _____/_____/_____/

Father: _____ Work Phone#_____

Date of Birth: _____/_____/_____/