DREXEL UNIVERSITY
Department of
Psychological and Brain Sciences
College of Arts and Sciences

Psychological Services Center

INITIAL INFORMATION FORM

Date: _____ Case Number: _____

Name of Client: _____ Birthdate: _____

Name of Person completing this form (if different from Client): _____
Family Income: _____ Number of Dependents: ___
Address: _____
_____
_____

May we leave messages for you at these numbers?

Telephone Numbers: Home: _____ ___ Yes ___ No
Work: _____ ___ Yes ___ No
Cell: _____ ___ Yes ___ No

Gender: _____ Pronouns: _____

Sexual Orientation: _____ (eg: he/she/hers/his/they/them)

Relationship Status: _____Single _____Legally Partnered (e.g., married, civil union) _____Widowed _____Other: _____

Religious Affiliation: _____

Self-Defined Ethnicity (check all that apply):

___ Alaska Native
___ American Indian
___ Asian
___ Black or African American
___ Hispanic or Latino
___ Native Hawaiian or Other Pacific Islander
___ White
___ Other (Please Specify):_____

For Children and Adolescents:

Mother's Name: _____ Father's Name: _____
Address: _____ Address: _____
_____ _____
_____ _____
Phone: _____ Phone: _____

Primary Concerns (Check all that apply):

___ Depression
___ Anxiety/Worries
___ Panic Attacks
___ Conduct Problems
___ Anger Management Problems
___ Oppositional or Defiant Behavior
___ Poor Impulse Control
___ Hyperactivity
___ Attention Problems
___ Difficulty Concentrating
___ Difficulty with thinking clearly
___ Recurrent thoughts, impulses or images
___ Unable to resist doing things repeatedly
___ Change in Energy (Increase or Decrease)
___ Difficulty Sleeping
___ Appetite Change (Increase or Decrease)
___ Difficulty with eating
___ Weight Gain or Loss
___ Difficulty with Relationship
___ Sexual Problem
___ Learning Problems
___ Other:
_____

Recent Stresses

___ Loss of Job
____Divorce/Separation
___ Serious Accident
___ Death of close friend or relative.
___ Serious Illness or Hospitalization of self or family member
___ Frightening event, please specify:
_____
___ Other:
_____

Have you ever experienced a trauma? ___ Yes ___ No

MEDICAL HISTORY

Name of Physician: _____ Telephone Number: _____
Address of Physician:_____
_____
_____

Date of most recent physical: _____

Medical Problems

___ Heart Problems
___ Respiratory Problems
___ Asthma
___ Cancer
___ Endocrine Problems
___ Arthritis
___ Seizures
___ Diabetes
___ Headaches
___ Gastrointestinal problems
___ Pain
___ Other:
_____

Serious Accidents/Head Injuries

Date Event

_____ _____

_____ _____

_____ _____

Hospitalizations

Dates Reason

_____ _____

_____ _____

_____ _____

Medications

Medication	Dose	Prescribed by	Side Effects

OTHER

Hobbies: _____

Current Job: _____

History of problems with work? ___ Yes ___ No

History of arrest: ___ Yes ___ No

Highest Level of Education Completed so far

___ No high school diploma and no GED
___ GED
___ High School Diploma
___ Some college but no degree
___ Associate's degree
___ Bachelor's or RN degree
___ Some graduate school but no graduate degree
___ Master's degree
___ Doctoral or law degree
___ Other

THIS PAGE IS ONLY FOR CHILD AND ADOLESCENT CLIENTS

DEVELOPMENTAL HISTORY

Check all that apply:

___ Difficulty with pregnancy
___ Difficulty with delivery
___ Alcohol or drug use during pregnancy

Developmental Milestones
Indicate ages at which your child learned to:

____ Sit up
____ Walk
____ First Words
____ Speak in sentences
____ Toilet Trained

SCHOOL

Name of School: _____
Grade: _____

Check all that apply:
___ Regular Education
___ Special Education – learning disability
___ Special Education – social emotional disability
___ Other school accommodations/services: _____

Recent Grades:
___ English/Language Arts
___ Math
___ Science
___ History/Social Studies