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## Client Information Form I

Today's date: \_\_\_\_\_

**Note:** If you have been a patient here before, please fill in only the information that has changed.

### A. Identification

Your name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Nicknames or aliases: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Home street address: \_\_\_\_\_ Apt.: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home/evening phone: \_\_\_\_\_ e-mail: \_\_\_\_\_  
Calls or e-mail will be discreet, but please indicate any restrictions: \_\_\_\_\_

### B. Referral: Who gave you my name to call?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

May I have your permission to thank this person for the referral?  Yes  No

How did this person explain how I might be of help to you? \_\_\_\_\_

### C. Religious and racial/ethnic identification

Religious denomination/affiliation:  Protestant  Catholic  Jewish  Islamic  Buddhist  
 Other (specify): \_\_\_\_\_  
Involvement:  None  Some/irregular  Active  
How important are spiritual concerns in your life? \_\_\_\_\_  
Which (if any) church, synagogue, temple, or meeting are you involved with? \_\_\_\_\_  
Ethnicity/national origin: \_\_\_\_\_ Race: \_\_\_\_\_  
Or other similar way you identify yourself and consider important: \_\_\_\_\_

### D. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment?  Yes  No

(cont.)

**E. Your current employer**

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Work phone: \_\_\_\_\_ Calls will be discreet, but please indicate any restrictions: \_\_\_\_\_

**F. Emergency information**

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Significant other/nearest friend or relative not residing with you: \_\_\_\_\_

**G. Your education and training**

Dates		Schools	Special classes?	Adjustment to school	Did you graduate?
From	To				

**H. Employment and military experiences**

Dates		Name of employer	Job title or duties	Reason for leaving
From	To			

**I. Family-of-origin history**

Relative	Name	Current age (or age at death)	Illnesses (or cause of death, if deceased)	Education	Occupation
Father					
Mother					
Brothers					

(cont.)

Sisters					
Stepparents					
Grandparents					
Uncles/aunts					

**J. Significant nonmarital relationships**

	Name of other person	Person's age when started	Your age when started	Your age when ended	Reasons for ending
First					
Second					
Third					
Current					

**K. Marital/relationship history**

	Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Is spouse remarried?
First					
Second					
Third					

**L. Children** (Indicate those from a previous marriage or relationship with "P" in the last column. Indicate stepchildren with "S.")

Name	Current age	Sex	School	Grade	Adjustment problems?	P? S?

*This is a strictly confidential patient medical record. Redislosure or transfer is expressly prohibited by law.*