Brigitte L. Lank Ph.D.
Clinical Psychologist
License # 20599
Psychotherapy and Consultation

The Marinwood Professional Center - 2400 Las Gallinas Avenue, Suite 160, San Rafael, CA 94903
Phone: 415.272.7758 - briglank@hotmail.com

Client Information Form

Name: ____________________ Date: ____________________

Address: ____________________ Age: ____________________

City, State Zip: ____

Telephone:

Home: ____________________ . ok to leave message? . yes . no

Wk: ____________________ . ok to leave message? . yes . no

Cell: ____________________ . ok to leave message? . yes . no

Other: ____________________ . ok to leave message? . yes . no

Email: ____________________ . ok to email you? . yes . no

Ethnic/racial background: ____________________
Sexual orientation: ____________________
Religious/spiritual background: ____________________
Involvement in religious/spiritual activities: . none . some/irregular . active

Emergency Contact

Name: ____________________
Relationship to you: ____________________
Address: ____________________
City, State, Zip:
Phone: ____________________

How did you hear about my services? ____________________
May I have your consent/permission to consult with this person coordination of treatment?
. yes . no

Please describe why you are seeking therapy:

____
____
____
____

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Education / Training

Education and Training

Dates	Schools/Training	Area(s) of study?	Date of graduation	Degree earned, If applicable

List any problems with school / adjustment to school:

____
____
____
____

Employment

Employment status: . full-time . part-time . unemployed . retired . disabled . student

Dates	Name of employer	Job Title / Duties /Profession	Reason for leaving

List any career/work problems/concerns:

____
____
____
____

Social / Family

Marital/relationship status: . single . married/partnered . separated . divorced . widowed

If married/partnered, how long? ____________________

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Marital/Relationship History

Spouse's/Partner's name	Spouse's/ Partner's age at commitment/marriage	Your age at commitment/marriage	Your age when separated/ divorced/widowed
First			
Second			
Third			

How do you get along with your current spouse or partner?

____
____
____

List any relationship problems/concerns:

____
____
____
____

Children

Name	Age	Sex	Living at home?	Describe Relationship
Name	Age	Sex	Living at home?	Describe Relationship
Name	Age	Sex	Living at home?	Describe Relationship
Name	Age	Sex	Living at home?	Describe Relationship

How do you get along with your children?

____
____
____

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What individual(s) in your life provide you with the greatest source of social/emotional support?
____
____
____

Family of Origin

Relative	Name	Living? (Y/N)	Age *(or age at death)*	Illnesses *(or cause of death)*	Occupation

Where were you born? ____________________
Where did you grow up? ____________________
Describe your parents' relationship with each other: ____________________
Describe your relationships with your parents: ____________________
Describe your relationships with your brothers/sisters (past & present): ____________________
List any abuse (e.g., physical, sexual, emotional, neglect)? ____________________
List any other relevant aspects of early development: ____________________

Medical / Psychiatric History

Name of primary medical care physician: ____________________
Date of last physical exam: ____________________
List current/past medical problems: ____________________
List any past surgeries: ____________________
Allergies: ____________________
Do you regularly experience physical pain? If so, please explain: ____________________
Please list all medications you are currently taking. ____________________

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Date began	Medication	Dosage	Purpose	With what results?

Have you ever been in counseling or therapy before? . yes . no

Dates	Age	Name of Therapist	Reason for therapy	With what results?

Are you currently receiving psychiatric medications from a psychiatrist/other physician? . yes . no
Name of provider: ____________________

Have you been prescribed medications for psychiatric/emotional problems in the past? . yes . no

Have you ever been hospitalized for psychiatric reasons? . yes . no

Dates	Age	Where hospitalized?	Reason for hospitalization

Does anyone in your family have a history of any mental health problems? If yes, who?
____

Depression ____________________
Bipolar/Manic-Depression ____________________
Anxiety (specify) ____________________
Obsessive Compulsive Disorder (OCD) ____________________
Schizophrenia ____________________
Alcohol/Drug Abuse/Dependence ____________________
Eating Disorder ____________________
Sexual Disorder____________________
Suicide ____________________
Other ____________________

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Other History

Substance Use/Dependence
How frequently do you drink alcohol? . never . infrequently . moderately . frequently . daily
How many alcoholic beverages do you consume each week (average)? ____________________
How frequently do you take drugs? . never . infrequently . moderately . frequently . daily
Which drugs have you used in the past 10 years? ____________________
How much tobacco do you smoke/chew each day? ____________________
How much caffeine do you consume each day? ____________________

Sleep
Do you have any problems getting enough sleep? If so, please describe:

____
____
____

Legal History
Is your reason for seeking therapy related to an accident or an injury? . yes . no
If yes, please explain:
____
____
____

Are you required by a court or probation/parole officer to have this appointment? . yes . no
If yes, please explain:
____
____
____

Are you presently suing anyone or thinking of suing anyone? . yes . no
If yes, please explain:

____
____
____

Additional Stressors
List/describe any additional stressors that you or close family members are currently dealing with:
____
____
____

Strengths
What are your personal strengths?
____
____
____

Anything else you would like to add which may be pertinent to your therapeutic work.

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