

LSH PSYCHOLOGICAL SERVICES
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Client Face Sheet

BACKGROUND INFORMATION

Name_____

Date_____

Address_____

Date of Birth_____

Phone Number_____

Cell Phone_____

Can I Leave a Message? Y N

OCCUPATION INFORMATION

Employer_____

Position_____

Spouse's Employer_____

Position_____

FAMILY HISTORY

Relationship Status Single Married Divorced Separated Widowed

Children Y N

Number of Children_____

People Residing in the Home

_____ Age_____

_____ Age_____

_____ Age_____

_____ Age_____

_____ Age_____

MEDICAL HISTORY

Physician's Name _____

Number _____

Address _____

Fax _____

Can I Contact Your Physician? Y N

Date of Your Last Physical? _____

Are You on Any Medication? Y N

PSYCHOLOGICAL HISTORY

Have You Ever Been in Treatment Before? Y N

Date of Treatment _____

How Long _____

Where _____

Reason for Leaving _____

Reason(s) for Seeking Treatment _____

What Made You Aware of the Issue _____

Desired Outcome _____