Vanessa Weinbach, Ph.D.
Clinical Psychologist, lic. 3681
6 Riverfield Dr., Westport, CT 06880 ~ 203.343.4208

Client Information Form

First, Middle, Last Name _____ Preferred Name _____

Date of Birth (mm/dd/yyyy) _____ Age _____ Ethnicity/Nationality _____

Sex (female/male/non-binary/other) & Sex Assigned at birth (if different) _____

Sexual Orientation _____ Place of Birth (City & State) _____

Religious/Spiritual Affiliation _____ Practicing? _____

Relational Status: Single Committed Relationship Married

Separated Divorced Widowed

Residential/Local Address _____

Mailing Address (if different) _____

Home Telephone _____ Work Telephone _____ Mobile _____

Best number to call? Home Work Mobile No Preference

Is it okay to leave a message? YES NO

Email Address _____

Is it okay to send you an email message? YES NO

Name(s)/age(s) of children _____

Emergency Contact _____ Relationship _____

Emergency Contact's Telephone and Address _____

How did you find me?

_____

May I thank the referral source? YES NO

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_____ _____
Employer/School Job/Position/Area of Study

_____
Employer/School Address

Name of your primary care physician: _____

Name of your psychiatrist (if applicable): _____

Are you currently taking any medications? **YES NO** If Yes, please list the names of medications, dosage, date started/duration:

_____

_____

Have you had any previous counseling or psychotherapy? **YES NO** If Yes, please list the dates, durations, and names of providers of treatments:

_____

_____

_____

Any current or past health problems? **YES NO** If Yes, please describe:

_____

Any current or past suicidal thoughts or behaviors? **YES NO** If Yes, please describe:

_____

Your goal(s) for therapy:

_____

_____

Any concerns about therapy?

_____

Note: All information provided is confidential and will not be released to anyone without your written authorization, except as explained in the Consent For Treatment.