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**CLIENT INFORMATION FORM**

DATE \_\_\_\_\_

NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY/ZIP \_\_\_\_\_

HOME PHONE # \_\_\_\_\_

BUSINESS # \_\_\_\_\_ CELL# \_\_\_\_\_

At which of these numbers may I leave messages? \_\_\_\_\_

May I contact you by mail? YES \_\_\_\_\_ NO \_\_\_\_\_

DRIVER'S LIC \_\_\_\_\_ OCCUPATION \_\_\_\_\_

APPROXIMATE YEARLY INCOME \_\_\_\_\_

EDUCATION (LIST DEGREES) \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_ CHILDREN/ AGES \_\_\_\_\_

WITH WHOM DO YOU LIVE? SPOUSE \_\_\_\_\_ PARENTS \_\_\_\_\_ OTHER \_\_\_\_\_

LIST 2 PERSONS TO BE CONTACTED IN CASE OF AN EMERGENCY

NAME/RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

NAME/RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

PLEASE LIST ANY CURRENT HEALTH PROBLEMS

\_\_\_\_\_

PLEASE LIST ANY MEDICATIONS AND DOSAGES

\_\_\_\_\_

PHYSICIAN'S NAME/ PHONE # \_\_\_\_\_

HAVE YOU BEEN HOSPITALIZED FOR PSYCHOLOGICAL REASONS OR DRUG DEPENDENCY?

YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, please describe \_\_\_\_\_

NAME/ NUMBER OF PSYCHIATRIST (If Applicable) \_\_\_\_\_

ISSUES THAT BRING YOU TO THERAPY

\_\_\_\_\_

PRIOR THERAPIST (S) AND LENGTH OF THERAPY

\_\_\_\_\_

REFERRED BY \_\_\_\_\_ PERMISSION TO ACKNOWLEDGE? \_\_\_\_\_

