ABBEY NEUROPSYCHOLOGY CLINIC
366 S. California Avenue, Suite 14
Palo Alto, CA 94306
Ph: 650-614-0024
Fax: 650-204-6502

NEW CLIENT INFORMATION SHEET (ADULT)

Name:____
Last First MI

DOB:________________________ **Age:** ________

Address: ____
Street

____
City State Zip

Telephone: Home:_______________ **Work:** ______________ **Cell:** ____________

When is the best time to reach you? ________________________________

Who referred you to the Abbey Neuropsychology Clinic? ______________________

Emergency Contact Person:

Name: ______________________ **Phone:**_______________ **Relationship:**_________

Race/Ethnicity:____

Religion/Spirituality: ____

Relationship Status: ____

Do you have children? ___**Yes** ___**No**

1. **Name:** ___________________ **Age:** _____ **Gender:**____
2. **Name:** ___________________ **Age:** ______ **Gender:** ___
3. **Name:** ___________________ **Age:** ______ **Gender:** ____
4. **Name:** ___________________ **Age:** ______ **Gender:** ____

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Education:

- ☐ 8 years or less
- ☐ Some high school
- ☐ Graduated high school
- ☐ Some college
- ☐ Graduated college
- ☐ Some graduate school
- ☐ Graduate degree: ____________________
  ____

Medical/Mental Health:

1. Have you received mental health treatment in the past? **YES NO**

If yes, please explain: ____
____
____
____
____
____
____

2. Are you currently taking any medications? **YES NO**

If yes, please list: ____
____
____

3. Primary care physician: Name: ____

Address: ____
____
____

Phone: ____

Date of last physical examination: ____________________

I would like to fill out a release of information for this individual: **YES NO**

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4. Release of Information: Please list any other names and contact information for all persons who you would like to release information to.

Name:________________________________ **Phone:**__________________________
Name:________________________________ **Phone:**__________________________
Name:________________________________ **Phone:**__________________________
Name:________________________________ **Phone:**__________________________

5. List any major medical problems that you have: _______________________________
____
____

6. Have you or any member of your family suffered from or been treated for a mental disorder? **YES NO**
If yes, please elaborate: ____
____
____

7. Have you ever sustained a brain injury? **YES NO**
If yes, please elaborate: ____
____

8. Have you ever had a seizure? **YES NO**
If yes, when? ____

9. Substance Use:

Have you ever had problems related to alcohol or drug use? **YES NO**

Have you ever received treatment for substance abuse? **YES NO**

Has a family member ever suffered from substance abuse? **YES NO**

Please provide details: ____
____

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REASONS FOR SEEKING EVALUATION OR THERAPY

Please provide a short description of the concerns that have brought you to the Abbey Neuropsychology Clinic:

____
____
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Please check any of the following issues that have affected you:

- ☐ Abuse
- ☐ Academic performance
- ☐ Alcohol
- ☐ Anger
- ☐ Anxiety
- ☐ Assertiveness
- ☐ Attention problems
- ☐ Body image
- ☐ Career choice
- ☐ Children
- ☐ Clarifying personal weaknesses
- ☐ Compulsivity
- ☐ Death of a friend or family member
- ☐ Depression
- ☐ Divorce
- ☐ Drug use
- ☐ Eating behavior
- ☐ Family problems
- ☐ Fears
- ☐ Finances
- ☐ Guilt
- ☐ Headaches
- ☐ Impulsivity
- ☐ Inhibition
- ☐ Isolation
- ☐ Job dissatisfaction
- ☐ Legal matters
- ☐ Living situation
- ☐ Loneliness
- ☐ Making decisions
- ☐ Marriage
- ☐ Memory
- ☐ Nicotine use
- ☐ Panic attacks
- ☐ Parenting issues
- ☐ Planning and organization
- ☐ Procrastination
- ☐ Relationship issues
- ☐ Self concept
- ☐ Self control
- ☐ Self efficacy
- ☐ Separation
- ☐ Shyness
- ☐ Sleeping problems
- ☐ Spirituality/ religion
- ☐ Stress
- ☐ Suicidal thoughts
- ☐ Task initiation or completion
- ☐ Temper outbursts
- ☐ Test anxiety
- ☐ Time management
- ☐ Tiredness
- ☐ Unhappiness
- ☐ Violence
- ☐ Worry
- ☐ Other: ________________

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Please describe your goals for treatment/assessment:

____
____
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____

Is there anything else that you think we should be aware of in order to help you meet your treatment goals?

____
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____
____

Client Signature: ____ Date: ____________