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NEW CLIENT FORM

Identifying Information

Name:

Phone:

Date of Birth: Age:

Address:

Email Address:

Gender: Sexual Identity:

Ethnicity:

Religious Beliefs:

Educational Background:

Are you currently a student? School name:

Are you currently employed? Occupation: Employer:

Emergency Contact Name, Relationship, Phone Number, Email:

Health Insurance Information (skip to next section if private pay or out of network)

Insurance Company Name:

Insurance Company Address:

Behavioral Health Phone Number on Insurance Card:

Policy Number:

Subscriber Name (if different):

Subscriber Date of Birth: Relationship to Subscriber:

Psychiatric History

Have you ever been in therapy before? If yes, please provide dates and names of providers:

Have you ever had an inpatient, partial hospitalization/day treatment, and/or intensive outpatient treatment? If yes, please elaborate:

Have you ever taken or are you currently on psychotropic medication? If yes, please include prescriber, names of medication and doses:

Family & Social History

Who is in your family? (Parents, spouse/partner/significant other, siblings, children, other important people in your life):

Is there any family history of mental illness, substance abuse, eating disorders or suicide attempts? If yes, please elaborate:

Has anyone in the past or is anyone currently harming you verbally, physically, emotionally, or sexually? If yes, please elaborate:

Medical History

Please include significant past or current physical illness, injuries, hospitalizations, medications:

Primary Medical Provider (name, phone, date of your last exam)

Presenting Concern

What brings you to therapy now? What are your goals?