C. A. CHILDRESS, Psy.D.
LICENSED CLINICAL PSYCHOLOGIST, PSY 18857

Client Information

Client Information

Name _____ Date of birth _____

Address _____ Social Security # _____

_____ _____

Phone Home _____ Cell _____ Work _____

E-mail _____ ☐ Single

Occupation _____ ☐ Married/Partnered

Address _____ ☐ Divorced

_____ ☐ Widowed

Spouse or Partner Information

Name _____

Work phone: _____ Cell phone: _____

What is your primary concern: _____

Previous or Current Psychological – Psychiatric – Medical Conditions

Please indicate all previous or current conditions or diagnoses you have received:

☐ Depression	☐ Victim of Child Abuse - Domestic Violence
☐ Bipolar Disorder	☐ Learning Disability
☐ General Anxiety	☐ Allergies: _____
☐ Panic Attacks	☐ Asthma
☐ Substance Abuse	☐ Seizures
☐ Attention Deficit Hyperactivity Disorder	☐ Prior head trauma or loss of consciousness

☐ Other Psychological – Psychiatric – Medical – or Neurological Conditions (please specify):

_____

_____

Current Medications

Please list all medications currently taken or prescribed for you:

_____ _____

_____ _____

_____ _____