livewell
psychological services

Client Data Form

Name_____
Last First

Address: _____
Street Apt. #

_____
City State Zip

Email address (optional) _____

Date of Birth: _____ Age:_____

Phone #'s: _____(home)

_____(work)

_____(cell)

May we leave a message at home? ☐ yes ☐ no
May we leave a message at work? ☐ yes ☐ no
May we leave a message on your cell? ☐ yes ☐ no

Marital Status: ☐S ☐M ☐D ☐W ☐Co-habitating

Partner's Name: _____

Children? (Names/Ages)

_____

Occupation: _____

Highest Level of Education: _____

Who referred you to LiveWell Psychological Services?

_____
Name *Relationship to Client*

_____
Address (if known) *Phone (if known)*

If we may contact your referral source to acknowledge the referral, please sign below.

_____ Yes, please contact my referral source.

_____
Signature

_____No, please do NOT contact my referral source.

Primary Physician:

_____
Name

_____
Address (if known) *Phone (if known)*

_____Please send a full report regarding my initial evaluation to my physician.

_____
Signature

_____Please do NOT contact my physician.

What is your primary reason for visiting LiveWell Psychological Services? _____
Please check all that apply:

- ☐ Sadness/Depression
- ☐ Anxiety/Fears/Nervousness
- ☐ Stress
- ☐ Relationship Issues
- ☐ Parenting concerns
- ☐ Grief/Loss
- ☐ Other, specify:_____
- ☐ Medical/Health concerns
- ☐ Sleep issues
- ☐ Suicidal thoughts
- ☐ Anger
- ☐ Underweight
- ☐ Overweight
- ☐ Eating concerns
  - ☐ undereating
  - ☐ overeating
  - ☐ bingeing
  - ☐ purging
  - ☐ overexercising