Dana Season, Psy.D.
Licensed Clinical Psychologist: PSY 23196

Date: _____

Client's name: _____

Person filling out form if not client: _____

Address: _____

_____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Employer: _____

Work Address: _____

Occupation: _____

Education/Years in School: _____

Marital Status: _____

How long together or separated: _____

Partner's Name: _____

Partner's Occupation: _____

Children: YES / NO
Names and ages: _____

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Emergency Contact Name: _____

Phone Number: _____

Why are you seeking treatment for yourself or for your child:

_____

_____

_____

Current medication taken by the client: (Drug/dose/frequency given):

_____

_____

Past or present in-patient or out-patient therapy for the client:

_____

History of suicidal/homicidal issues by client or in the family:

_____

Alcohol or drug use by the client or family members:

_____

_____

Physicians/ Psychiatrists name & phone number:

_____

For minor children: Married Joint custody Solo custody Legal Custody

Please sign below to indicate all information given is true and correct.

_____ _____

Patient signature Date