Mary Pat Kelly, Ph.D.
Clinical Psychologist
Lic. PSY 12662

380 Glenneyre • Suite D • Laguna Beach, CA 92651 • (949) 494-0093

Please fill out this form and bring it to your first session. NOTE: *Information you provide here is protected as confidential information.*

Private Client Information

Date_____

Name_____ Age_____ Birth date _____/____/_____ M or F

Home Address_____ Home Phone (_____) _____ ***OK to leave message?*** ☐YES ☐NO

_____ Cell Phone (_____) _____ ***OK to leave message?*** ☐YES ☐NO

City State Zip

Occupation_____ Soc. Sec. # _____-____-_____ Business Phone (_____) _____ ***OK to leave message?*** ☐YES ☐ NO

Marital Status_____ # of Children_____ Age & Gender of Children _____ _____

How did you about Dr. Kelly's practice? _____

May we send a note of thanks to those who referred you? ☐YES ☐YES, *but do not mention me by name*. ☐NO, I'd rather you did not.

Reason for seeking therapy at this time: _____

_____

_____

Major Life Events: Are there any major occurrences in your life which you feel contribute to your reasons for seeking therapy at this time? (Consider family and personal events – past or present)

_____

_____

Have you ever had therapy/counseling before? ☐YES ☐ NO If so, when and with whom? _____

_____

Please state briefly anything that was helpful or not helpful in your previous therapy experiences. (This information is very helpful in assuring that you get the kind of services that are best for you.)

_____

_____

_____

Please complete next page

Medical Information:

Are you presently under a doctor's care for a health problem? ☐YES ☐ NO _____
Physician's Name

If so, please describe your condition and care: _____:_____

_____

Is this condition likely to be ongoing? ☐YES ☐ NO Does this problem have any affect on your emotional well-being? ☐YES ☐ NO

If so, please describe _____

_____

Are you taking any prescription medication at this time? ☐YES ☐ NO If so, What and How Much? Please list.

_____ _____ _____
Name of Prescription and Dosage | Name of Prescription and Dosage | Name of Prescription and Dosage

Family Mental Health History: In the section below, identify if there is a personal or family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (self, father, grandmother, uncle, etc.).

Check all that apply and List Family Member.

		Family Member			Family Member
Alcohol/Substance Abuse	☐YES ☐ NO	_____	Anxiety	☐YES ☐ NO	_____
Depression	☐YES ☐ NO	_____	Obsessive Compulsive Behavior	☐YES ☐ NO	_____
Bipolar/Manic-Depressive Illness	☐YES ☐ NO	_____	Eating Disorders	☐YES ☐ NO	_____
Suicide Attempts	☐YES ☐ NO	_____	Schizophrenia	☐YES ☐ NO	_____
Abuse/Domestic Violence	☐YES ☐ NO	_____	Other _____	☐YES ☐ NO	_____

Is there any other information you feel is important for your therapist to know which has not already been covered in this form? (Please explain).

_____

_____

_____

Note: Dr. Kelly does not contract with any insurance panels or bill insurance for payments. (See Client-Therapist Agreement for more information). ***If you plan to submit your receipt statements to your insurance for reimbursement, complete this section*** or if you have an insurance card listing all this information we can take a copy at the office for your file.

Insurance Co. _____ Policy # _____ Group # _____

Name of Insured _____ Plan # _____ Contract Code # _____

Insured's ID# _____ Insurance Co. Contact Phone # _____

Any other relevant identifying information or numbers on your card or policy _____

I look forward to working with you toward meeting your goals through therapy.