Frances E. Reinker, Ph.D.
Client Information Form

Name: _____ Date: ____/____/_____

Who referred you for this appointment? _____

Who is your primary care physician? _____

Are you currently under the care of a psychiatrist? Yes No
Name of psychiatrist: _____

Do you have any allergies to medications? Yes No
If yes, please list medications: _____

Please list all medications, vitamins and supplements you are currently taking. Please give the name of the medication, the dosage and the frequency.

_____
_____
_____
_____
_____
_____

Have you had previous mental health or substance abuse treatment? Yes No
If yes, please give approximate dates and the type of treatment received.

_____
_____
_____
_____

Please list any major health issues (past or present) you have received treatment for:

_____
_____
_____
_____
_____

What is your primary reason for making this appointment?

_____
_____
_____

What are your goals for treatment?

_____
_____
_____
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