KATIE LIEBENBERG THERAPY

Katie Liebenberg Psy.D
Licensed Clinical Psychologist
166 Kings Highway North
Westport, CT 06880
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PERSONAL DATA FORM

TO BE COMPLETED BY THE PATIENT: DATE: ___/___/____

LAST NAME _____ FIRST NAME _____ MIDDLE _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

DAY PHONE _____ EVENING PHONE _____

CELL PHONE _____ FAX NUMBER _____

OK TO LEAVE MESSAGE Y / N (circle) EMAIL ADDRESS _____

SEX _____ ETHNICITY _____ DATE OF BIRTH ___/___/____ AGE _____

MARITAL STATUS _____ RELIGION _____

EMPLOYER OR SCHOOL _____ OCCUPATION _____

EMERGENCY CONTACT _____ PHONE _____

PRIMARY CARE DOC _____ PHONE _____

PSYCHIATRIST _____ PHONE _____

CURRENT MEDICATIONS/DOSAGES _____
_____

PAST/PRESENT MEDICAL CONDITIONS _____
_____

HAVE YOU BEEN IN PSYCHOTHERAPY BEFORE: Y / N (circle) IF YES, THEN:

PLEASE LIST PREVIOUS THERAPIST(S) NAME(S), DATE RANGE OF SERVICE, REASON FOR TREATMENT, AND REASON FOR TERMINATION:

NAME	DATE RANGE	REASON FOR TX	REASON FOR TERMINATION

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REASON FOR TODAY'S VISIT _____
_____

AS A CHILD, DID YOU WALK ON TIME? Y / N (circle)

AS A CHILD, DID YOU TALK ON TIME? Y / N (circle)

WAS YOUR MOTHER'S PREGNANCY COMPLICATED? Y / N (circle) IF SO, HOW?
_____

WAS YOUR DELIVERY COMPLICATED? Y / N (circle) IF SO, HOW?

HIGHEST LEVEL OF EDUCATION COMPLETED _____

PLEASE LIST THE AGE OF EACH PARENT (OR AGE WHEN DECEASED):

MOTHER _____ FATHER _____ DO YOU HAVE SIBLINGS? Y / N (circle) IF SO, LIST SEX AND AGE OF EACH _____

HAVE ANY OF THE FOLLOWING RELATIVES HAD PSYCHOLOGICAL DIFFICULTIES (WHETHER OR NOT THEY RECEIVED TREATMENT):

RELATIVE	YES / NO	TYPE OF PROBLEM (e.g., anxiety, depression, bipolar, schizophrenia, etc.)
MOTHER		
FATHER		
SIBLINGS		
AUNTS/UNCLES		
COUSINS		
GRANDPARENTS		