Robert L. Kaufman, Ph.D., A.B.P.P.

Diplomate in Forensic Psychology • American Board of Professional Psychology

CLIENT INFORMATION

NAME:____**AGE:**_______**SEX:**________

TODAY'S DATE:___________________**BIRTHDATE:**____________________________

HOME ADDRESS:____

_______________________________**EMAIL:** _________________________________

HOME PHONE:___________________**BUSINESS PHONE:**________________________

FAX: ___________________________ **CELL PHONE:** ___________________________

OCCUPATION:____________________ **EMPLOYER:**_____________________________

MARITAL STATUS:_________________

DATE(S) OF MARRIAGE(S):____

DATE(S) OF DIVORCES(S):____

HAVE YOU SEEN A PSYCHOLOGIST OR THERAPIST BEFORE?_____________________

IF SO, WHEN?____________________**WHERE?**_________________________________

PREVIOUS THERAPIST(S):____

HAVE YOU EVER BEEN HOSPITALIZED FOR A PSYCHIATRIC DISORDER? ___________

IF SO, WHEN AND WHERE?____

DO YOU SUFFER FROM ANY MEDICAL PROBLEMS?______________________________

IF SO, PLEASE LIST:____

CURRENT MEDICATIONS: ____

5625 College Avenue, Suite 209; Oakland, CA 94618; Tel: (510) 428-1602
207 Miller Avenue, Suite 2; Mill Valley, CA 94941; Tel: (415) 383-1857
Ca License: PSY 9808 • Fax: (415) 383-6264

FAMILY MEMBERS AND OTHERS NOW IN HOUSEHOLD

NAME RELATIONSHIP AGE OCCUPATION

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____

____

____

CHILDREN LIVING AWAY FROM HOME

____

____

IF YOU ARE CURRENTLY INVOLVED IN A LEGAL PROCEEDING RELATED TO YOUR SEEKING CONSULTATION, PLEASE PROVIDE THE NAME, ADDRESS AND PHONE NUMBER OF YOUR ATTORNEY:

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IF YOU ARE BRINGING IN YOUR CHILD FOR EVALUATION OR TREATMENT, PLEASE PROVIDE THE FOLLOWING INFORMATION:

NAME/ADDRESS/PHONE OF OTHER PARENT (IF NOT LIVING IN SAME HOUSEHOLD AS PARENT FILLING OUT THIS FORM):

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CHILD'S SCHOOL:______________________________**GRADE:**______________

CHILD'S PEDIATRICIAN:____

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