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Confidential Client Information

Welcome! We want to make the most of each appointment you have with me. One way of doing this is for you to write down some basic information in advance of your first appointment. Please fill out the following as completely and legibly as possible. This information is confidential. If you have concerns about the relevance of any information and wish to leave it out, please feel free to do so.

Name: _____

Parent(s)/Guardian name (if under 18): _____

Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Cell phone: _____ Can I leave a message/text yes no (check one)

Home number: _____ Can I leave a message/text: yes no (check one)

Email: _____ May I email you? yes no (check one)

*Please note: Email correspondence is not considered to be a confidential medium of communication

Referred by (if any): _____

Age: _____ Birthdate: _____ Birthplace: _____

Education (grade completed, any postsecondary): _____

Current Occupation: _____

Person to alert in the event of medical emergency: _____

Relationship to you: _____ Phone: _____

Family Doctor: _____ Phone: _____

Relationship status (circle one): Single Married Partnered Separated Divorced Widowed

Spouse/partner's first name: _____ Age: _____ Yrs in relationship: _____

Children (gender, age): _____

Have you previously received any type of mental health services (therapy, counseling, psychiatric services, etc.)? Yes No

If yes, please give the name of the previous therapist(s), the months you saw them (e.g., Nov 12 - Feb 13), and the nature of the difficulty at the time.

Have you ever been hospitalized for a psychological difficulty? Yes No

If yes, please give the dates and the nature of the difficulty at the time: _____

Please list any medications you currently take. Include prescription and over-the-counter medications and the dosage of each.

How would you rate your physical health? Please describe any significant current or past medical problems: _____

How would you describe your:

Sleeping habits ___poor ___satisfactory ___ good ___ very good

Eating habits ___poor ___satisfactory ___ good ___ very good

Do you exercise regularly? ___yes ___no

What form (s)? _____

Are you currently experiencing feelings of sadness, grief or depression? _____

If yes, for how long? _____

Are you currently experiencing anxiety, panic attacks or phobias? _____

If yes, please describe _____

Do you currently use alcohol or other substances? _____

If yes, please describe _____

What are some of your strengths?

What are some of your weaknesses? _____

Do you have a family history of mental health/substance use concerns? _____

In your own words, what is the nature of the concern that you wish to address in therapy? Feel free to describe this in as much or as little detail as you wish.

Therapy can be a powerful force for change. In order for it to be most effective it helps to have a clear and specific goal. You may find it difficult to express your hopes for therapy in the form of a goal, but please make at least an initial effort. You can discuss this further with me at the time of our appointment. Feel free to list more than one goal if you wish.
