

# CENTER FOR COGNITIVE THERAPY

22022 Hula Circle • Huntington Beach CA 92646 • Voice Mail 714.963.0528  
Co-Founders Christine A. Padesky, PhD & Kathleen A. Mooney, PhD • Founded 1983

## CLIENT INFORMATION FORM

We appreciate your cooperation in thoroughly completing this form. It is very helpful in planning our services for you. Please answer each item carefully and completely. All information on this form is confidential.

Client's Full Name (please print): \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relationship Status: \_\_\_\_\_ Anniversary Date: : \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Home Address: \_\_\_\_\_  
(Street) (City) (State, Zip Code)

Home Telephone: ( ) \_\_\_\_\_ Cell Phone Number: ( ) \_\_\_\_\_

Other Telephone Number: ( ) \_\_\_\_\_ Education (in years): \_\_\_\_ Highest Degree: \_\_\_\_

Occupation: \_\_\_\_\_ Current Position: \_\_\_\_\_ How Long? \_\_\_\_\_

Employed By: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Work Address: \_\_\_\_\_  
(Street) (City) (State, Zip Code)

BRIEFLY DESCRIBE YOUR REASONS FOR SEEKING HELP \_\_\_\_\_

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Have you ever seen a psychotherapist / counselor of any type before? What were the reasons and outcome?

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Describe any major changes in your life in the past two years: \_\_\_\_\_

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List all medications you are now taking. Prescription (including birth control pills) and nonprescription (such as aspirin, allergy medication, vitamins, etc.).

MEDICATION	DOSAGE (AMOUNT & TIMES/DAY)	REASON

Physician: \_\_\_\_\_ Telephone: (     ) \_\_\_\_\_

Address: \_\_\_\_\_

Date of Last Physical Exam: \_\_\_\_\_ Describe any health problems: \_\_\_\_\_

Are You Pregnant? No: \_\_\_\_ Unsure: \_\_\_\_ Yes: \_\_\_\_ How many months? \_\_\_\_

Do You Smoke? No: \_\_\_\_ Yes: \_\_\_\_ How much? \_\_\_\_\_

Do You Drink Coffee/Caffeinated Drinks? No: \_\_\_\_ Yes: \_\_\_\_ If Yes, how much? \_\_\_\_\_

Alcohol Intake? (describe average weekly intake) \_\_\_\_\_

Do You Exercise Regularly? No: \_\_\_\_ Yes: \_\_\_\_ (specify type of exercise) \_\_\_\_\_

PLEASE CHECK (✓) ANY OF THE FOLLOWING AREAS IN WHICH YOU ARE HAVING DIFFICULTY			
<input type="checkbox"/> Aggressive Behavior	<input type="checkbox"/> Divorce	<input type="checkbox"/> Impulsiveness	<input type="checkbox"/> Relaxation
<input type="checkbox"/> Alcohol Use	<input type="checkbox"/> Drug Use	<input type="checkbox"/> Irritability	<input type="checkbox"/> Self-Control
<input type="checkbox"/> Anger	<input type="checkbox"/> Eating Problems	<input type="checkbox"/> Isolation	<input type="checkbox"/> Self-Esteem
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Education	<input type="checkbox"/> Legal Matters	<input type="checkbox"/> Sexual Problems
<input type="checkbox"/> Assertiveness	<input type="checkbox"/> Energy	<input type="checkbox"/> Loneliness	<input type="checkbox"/> Shame
<input type="checkbox"/> Being a Parent	<input type="checkbox"/> Family	<input type="checkbox"/> Making Decisions	<input type="checkbox"/> Shyness
<input type="checkbox"/> Boredom	<input type="checkbox"/> Fears	<input type="checkbox"/> Marriage	<input type="checkbox"/> Sleep
<input type="checkbox"/> Bowel Troubles	<input type="checkbox"/> Finances	<input type="checkbox"/> Memory	<input type="checkbox"/> Stress
<input type="checkbox"/> Career Choices	<input type="checkbox"/> Friends	<input type="checkbox"/> My Thoughts	<input type="checkbox"/> Sudden Change of Mood
<input type="checkbox"/> Children	<input type="checkbox"/> Grief	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Suicidal Thoughts
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Guilt	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Upsetting Memories
<input type="checkbox"/> Concentration	<input type="checkbox"/> Headaches	<input type="checkbox"/> Panic	<input type="checkbox"/> Unhappiness
<input type="checkbox"/> Dating Skills	<input type="checkbox"/> Health Worries	<input type="checkbox"/> Perfectionism	<input type="checkbox"/> Work
<input type="checkbox"/> Depression	<input type="checkbox"/> Health Problems	<input type="checkbox"/> Relationships	<input type="checkbox"/> Worry
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

List the people currently living in your home (please include your pets):

NAME	AGE	RELATIONSHIP	OCCUPATION

Feel free to add any additional information which you feel would be useful to us.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who referred you to the Center?

May we have your permission to thank them for your referral?  Yes  No  Let's discuss

Phone Number: (     ) \_\_\_\_\_

City: \_\_\_\_\_

Have you been seen here before?  No  Yes, year seen was \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State, Zip Code)

PHONE: Daytime (     ) \_\_\_\_\_ Evenings (     ) \_\_\_\_\_

**Thank you for providing this information.  
Full payment is expected at the time services are rendered unless other arrangements are made. If cancellation is not made 24 hours in advance, you may be charged full session fees.**

**I HEREBY GUARANTEE PAYMENT OF SERVICES TO THE CENTER FOR COGNITIVE THERAPY.**

Payment is due at the time services are rendered. All charges are the direct responsibility of the client.

We cannot render services on the assumption that our charges will be paid by an insurance company. Insurance is an agreement between you and your insurance company. If we have problems collecting payment from you, we will also add attorney's fees, collection agency costs and any related fees to your bill.

I understand the fee for a returned check is \$15<sup>00</sup> and that I will be charged a 1.5% finance charge on all accounts over 30 days.

I hereby acknowledge that I have read, understand and guarantee payment of services to the Center for Cognitive Therapy. I further agree that a photocopy of this agreement shall be as valid as the original.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Print Name of Responsible Party

\_\_\_\_\_  
Date

**ACKNOWLEDGE RECEIPT OF HIPAA FORM**

I acknowledge that I have received a copy of the California HIPAA Notice Form (#09192003) provided by the Center for Cognitive Therapy. I understand this acknowledgment will be retained in my medical record.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date