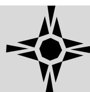

LAUREN H. KERSTEIN LCSW, P.C.

Child and Family Psychotherapist

CLIENT INFORMATION SHEET

Name: (*First, Middle, Last*): ______________________________

Address: ______________________________

____

Home Telephone: ______________ Cell Phone: ______________

Date of Birth: ______________ Age: ______________

Client Information	Spouse Information
W Telephone: ______________	W Telephone: ______________
Cell Phone: ______________	Cell Phone: ______________
Profession: ______________	Profession: ______________
Email: ______________	Email: ______________

Primary Care Physician

Name: ______________________________

Address: ______________________________

____

Phone Number: ______________________________

Is there information that would be helpful for me to obtain from your PCP? Yes No

Please list the members of your household: (name, age, relationship) ______________________________

____

Referral Source

How did you hear about Lauren Kerstein? ______________________________

Please include the address for your referral source if you have it: ______________________________

Are you taking any medications? Yes No

If yes, please list the medication and dosage. ______________________________

Have you ever received psychotherapy services in the past? Yes No

If so, with whom? ______________________________

Please list any therapists and their phone numbers who are currently involved with you or your family:___________

6365 S. Ironton Court Englewood CO 80111 Phone 303.284.3603 lhkerstein@comcast.net

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Have you received medical or psychological diagnoses in the past? Yes No

If yes, please list diagnoses. ____

Please state the nature of your concerns:____

____

____

____

Family History (Please check items that apply.) UK = Unknown, M=Maternal Side of Family, P=Paternal Side of Family, Ch: Your children

Diagnosis	Yes	No	UK	M,P,C,S	Diagnosis	Yes	No	UK	M,P,C,S
Depression					Metabolic Disorder				
Anxiety					Heart Disease				
Bipolar Disorder					Allergies				
ADD/ADHD					Asthma				
Sleep Disorder					Sinus Infections				
Autism/Asperger's/ PDD					**Obsessive - Compulsive Disorder**				
Tourette's					Sensory Integration				
Genetic Disorder					Substance Abuse				
Fragile X					Other:				

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