AustinOCD  Bruce Mansbridge, PhD, Licensed Psychologist PLLC
5217 Old Spicewood Springs Road #805, Austin, TX 78731 • 512 626-3900 • mansbridge@austinocd.com

Client Information (Adult)

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Today's date: _____ Date of first appointment, if different: _____

A. IDENTIFICATION:

Your name: _____ Date of birth: _____ Age: _____

Any nicknames or aliases: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ E-mail: _____

Cell phone: _____ Calls and e-mails will be discreet, but please indicate any restrictions:_____

_____

People you live with (names, ages, relationship): _____

_____

B. REFERRAL: Who gave you our name to call?

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: ____ Zip: _____

May we have your permission to thank this person for referring you? ☐ Yes ☐ No ☐ N/A

C. YOUR MEDICAL CARE: From whom or where do you get your medical care?

Doctor / clinic name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: ____ Zip: _____

If you enter treatment with us, may we inform your physician in order to coordinate your treatment? ☐ Yes ☐ No

Date of last complete physical exam: _____ List any medical conditions you have: _____

_____

List ALL medications you take regularly: _____

D. CURRENT EMPLOYMENT:

Employer: _____ For how long? _____

Address: _____ City: _____ State: ____ Zip: _____

Position (please describe what you do): _____

_____

Work phone: _____ Calls will be discreet, but please indicate any restrictions: _____

_____

E. EDUCATION AND TRAINING:

Highest grade you completed in school: _____ Year: _____ Major/best subject: _____

Please indicate any special training: _____

_____

F. SIGNIFICANT PREVIOUS EMPLOYMENT AND MILITARY EXPERIENCE:

Dates From	To	Name of military or employers	Job title or duties	Reason for leaving
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

G. FAMILY-OF-ORIGIN HISTORY:

Relative	Name	Living?	Current age (or age at death)	History of OCD or mental illness?	Education	Occupation
Father	_____	___	_____	_____	_____	_____
Mother	_____	___	_____	_____	_____	_____
Sisters/	_____	___	_____	_____	_____	_____
Brothers	_____	___	_____	_____	_____	_____
	_____	___	_____	_____	_____	_____

List any other blood relatives with a history of OCD or mental illness:

_____	___	_____	_____	_____	_____
_____	___	_____	_____	_____	_____

H. CURRENT AND PREVIOUS COUNSELING, PSYCHOTHERAPY, PSYCHIATRIC HOSPITALIZATIONS:

Dates From	To	Name of therapist	Focus of treatment	What does/did treatment consist of?	Is/was it helpful?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

I. CURRENT AND PREVIOUS PSYCHOTROPIC MEDICATION:

Dates From	To	Name of medication	Dosage	What is/was it intended to do?	Is/was it helpful?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____