

Carol Twitchell, Psy.D.  
Clinical Psychologist

**CONFIDENTIAL BACKGROUND INFORMATION**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_  
\_\_\_\_\_

AGE \_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_ MARITAL STATUS \_\_\_\_\_

PHONE HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

SOC. SEC. # \_\_\_\_\_ EDUCATION \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

PERSONAL PHYSICIAN \_\_\_\_\_

MAJOR HEALTH PROBLEMS \_\_\_\_\_

CURRENT MEDICATIONS \_\_\_\_\_

IN CASE OF EMERGENCY, NOTIFY \_\_\_\_\_

TELEPHONE \_\_\_\_\_

REFERRAL SOURCE \_\_\_\_\_

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

DATES AND REASONS FOR PREVIOUS MENTAL HEALTH TREATMENT  
\_\_\_\_\_  
\_\_\_\_\_

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

Carol Twitchell, Psy.D.  
Clinical Psychologist

I acknowledge receipt of the Psychotherapist-Client Services Agreement and agree to abide by its terms.

Client's Signature \_\_\_\_\_ Date \_\_\_\_\_

I acknowledge receipt of the Notice of My Policies and Practices to Protect the Privacy of Your Health Information.

Client's Signature \_\_\_\_\_ Date \_\_\_\_\_

*Signatures below only for those using insurance:*

I authorize the release of any medical or other information necessary to process my insurance claim.

I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Client's Signature \_\_\_\_\_ Date \_\_\_\_\_

I authorize payment of medical benefits to Carol Twitchell, Psy.D. for services rendered.

Client's Signature \_\_\_\_\_ Date \_\_\_\_\_