Client Information Form

Nusha Askari, Ph.D., PSY31985

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Today's Date________________________ New Client ☐ Yes ☐ No

First Name____________________________Last Name___________________________MI____
Date of Birth (mm/dd/year)____________________Age_________☐ Check if Under 18 Years
Address______________________________City_______________State____Zip____________
Phone (Home)_________________________ Phone (Cell) __________________________
Phone (Work)_________________________ ϒ Check if ok to leave a voice mail

Gender ☐ Male ☐ Female ☐ Trans ☐ Non-Binary
☐ Prefer Not to Answer

Marital Status ☐ Single ☐ Married ☐ Domestic Partners ☐ Separated
☐ Divorced ☐ Widowed ☐ Prefer Not to Answer

Cultural Background ☐ Black/African American ☐ Native American/Alaskan Native
☐ Middle Eastern ☐ White
☐ Asian/Southeast Asian ☐ Hispanic/Non-Hispanic Latino
☐ Multicultural ☐ Other: _____________________

For Minor Receiving Services (Client Under the Age of 18 Years)

Name of Current School___________________________________Current Grade ____________
Parent/Guardian Name (if applicable)
First Name____________________________Last Name___________________________MI____
Parent/Guardian Name (if different from yours)
Address______________________________City_______________State____Zip____________
Phone (Home)__________________________ Phone (Cell) ___________________________

Parent/Guardian Name (if applicable)
First Name____________________________Last Name___________________________MI____
Parent/Guardian Name (if different from yours)
Address______________________________City_______________State____Zip____________
Phone (Home)__________________________ Phone (Cell) ___________________________

For Couples Receiving Services (Couples Counseling Client)

Spouse/Partner Name
First Name____________________________Last Name___________________________MI____
Spouse/Partner Name (if different from yours or does not live together)
Address______________________________City_______________State____Zip____________
Phone (Home)__________________________ Phone (Cell) ___________________________

How long have you been dating?__________ And/or married (if applicable)? ___________

How Happy Are You In Your Marriage/Relationship?
☐ Very Happy ☐ Happy ☐ Neutral ☐ Unhappy ☐ Very Unhappy

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Emergency Contact Information

In case of an emergency, please contact:

Name_______________________________ Relationship________________

Best Contact Number_____________________ ☐ Check if ok to leave a voice mail

Please sign here if you consent for Nusha LLC to contact the above-named individual in the event of an emergency____

Primary Care Doctor Information

First Name______________________Last Name______________________MI ___

Address________________________City____________State____Zip__________

Phone (Work)____________________Date of Last Physical Check-up ____________

☐ Yes ☐ No Currently, do you have any medical conditions?
If yes, please describe ______________________________________

☐ Yes ☐ No Currently, are you taking any medication for medical conditions?
If yes, please describe ______________________________________

☐ Yes ☐ No In the past, did you have any significant medical conditions?
If yes, please describe ______________________________________

☐ Yes ☐ No In the past, did you take any medication for any significant medical conditions?
If yes, please describe ______________________________________

Please list family history of medical conditions (if applicable) ______________________

Psychiatric Service Information

Name of Current Psychiatrist (if applicable)

First Name______________________Last Name______________________MI

Address________________________City____________State____Zip__________

Phone (Work)____________________Date of Last Appointment _______________

Psychiatrist Affiliation ☐ Kaiser Permanente ☐Sutter Health
☐ Stanford University/SHC ☐ Palo Alto Medical Foundation
☐ Private ☐ Other ____________________

Psychiatric Diagnosis ____

☐ Yes ☐ No Currently, are you taking any psychiatric medication such as antidepressants?
If yes, please describe ______________________________________

☐ Yes ☐ No Do your symptoms improve with the current psychiatric medications?

☐ Yes ☐No Do you notice any side effects of the current psychiatric medications?
If yes, please describe ______________________________________

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Psychiatric Services History

Name of Previous Psychiatrist (if applicable)
First Name______________________Last Name_____________________MI
Address________________________City____________State____Zip___________
Phone (Work)____________________Date of Last Appointment _____________

Psychiatrist Affiliation
☐ Kaiser Permanente ☐ Sutter Health
☐ Stanford University/SHC ☐ Palo Alto Medical Foundation
☐ Private ☐ Other

Psychiatric or Neurological Diagnosis ________________________________

☐ Yes ☐ No In the past, did you take any psychiatric/neurological medication such as antidepressants or Donepezil?
If yes, please describe ________________________________
☐ Yes ☐ No Did your symptoms improve with the previous psychiatric/neurological medications?
☐ Yes ☐ No Did you notice any side effects of the previous psychiatric/neurological medications?
If yes, please describe ________________________________
Please list family history of psychiatric/neurological conditions (if applicable) ____________
____

Behavioral and Mental Health Services

☐ Yes ☐ No Currently, are you receiving counseling service from providers besides Nusha?If yes, type of counseling service
☐ Individual Counseling ☐ Couples Counseling ☐ Family Counseling
☐ Group Counseling ☐ Life Coaching ☐ Other
Name of Provider/Organization ________________________________

☐ Yes ☐ No In the past, did you receive counseling service?
If yes, type of counseling service
☐ Individual Counseling ☐ Couples Counseling ☐ Family Counseling
☐ Group Counseling ☐ Life Coaching ☐Other
Name of Provider/Organization ________________________________

Risk Assessment

☐ Yes ☐ No Currently, are you thinking about hurting yourself or others?
If yes, please discuss this with the counselor for a personalized safety plan
☐Yes ☐No In the past, have you ever thought about hurting yourself or others?
If yes, how did you cope with the thought previously?

____

____

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Alcohol and Other Drugs Information

How often do you use alcohol or use recreational drugs?

☐Not at all ☐ Once/month or less ☐ 2 or more times/week ☐Daily

Do you think that you use alcohol to excess? ☐Yes ☐No

Do you think that you use drugs to excess? ☐Yes ☐No

Employment Information

Your Current Occupation______________________________ Hours of Work Per Week _________

Insurance Information

Primary Insurance Carrier______________________________ Member ID # ____________________

Subscriber Name______________________________________ Subscriber DOB __________________

Client Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

Third Party Payer Information

Name of Person Responsible for Payment to Nusha LLC

____

Client's Relationship to the above-named third-party payer

☐ Self ☐Spouse ☐ Parent ☐Child ☐ Other

If a third party is paying for your service at the Nusha LLC/Nusha Askari, PhD, please sign your name below to indicate your voluntary consent to third party payer's knowledge that you are receiving services at Nusha LLC: ____

Focused Service Areas

What is your reason for seeking out for counseling services at this time? Check all that applies

☐ Anger Management	☐ Addiction	☐Anxiety	☐Bullying
☐ Communication Issues	☐ Couples Issues	☐ Divorce	☐ Infidelity
☐ Issues with In-Laws	☐ Family Conflict	☐Loss and Grief	☐ Life Transitions
☐ Parenting Issues	☐ Pre-marital Counseling		☐ Psychotic Symptom
☐ Self-Esteem	☐ Trauma	☐Others (please specify in the box below)	

Is there anything else I should know?

Referral Resources

How did you hear about Nusha Askari/Nusha LLC?

☐ Word of Mouth ☐ Psychology Today ☐Internet Research ☐ Flyer ☐ Workshop

☐ Referral by Other Providers (please specify____)

☐ Other (please specify____)

Thank you for completing the form. Please bring the completed form to your first appointment, or contact me via email to send securely, or mail to PO Box 1783 Cupertino, CA 95015, no later than one week before your first appointment.