Leslie Hannon, Psy.D., LLC

Dr. Leslie Hannon, Clinical Psychologist
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Client Information

Name _____ Age _____ Birth Date _____

Address_____City_____State_____Zip _____

Employed by_____Occupation_____Years at company_____

Phone Number _____ Ok to leave VM/text? Y N (Circle one)

Email Address _____ Ok to send email? Y N (Circle one)

Emergency Contact _____ Relationship to you_____Phone #_____

Preferred Pronouns _____ Gender Identity _____

Relationship Status (Circle one)

Single Dating Committed Married Separated Divorced Widowed

Education (Circle highest level completed)

GED High School Vocational School Associates Bachelors Masters Doctorate

Do you have children? No Yes How many? _____

What brings you to therapy at this time?

_____

_____

_____

_____

Please check if you have ever experienced or are currently experiencing the following:

___Anxiety/Panic ___Sadness lasting more than a few days ___Periods of excessive energy

___Excessive anger ___History of experiencing abuse/trauma ___Relationship issues

___Excessive spending ___Eating disordered behavior ___Suicidal thoughts

___Suicide attempt(s) ___Seeing/hearing things others do not ___Legal involvement

___Memory difficulties ___Witness/Victim of domestic violence ___Excessive Worry

___Cutting/Burning ___Alcohol/Drug/Prescription medication abuse ___Attention difficulties

Any additional symptoms? If so, please describe. _____

_____

Do you have a history of, or do you currently have, significant medical issues? _____

_____

Currently, how are you sleeping? Any recent changes? _____

_____

Currently, how is your appetite? Any recent changes? _____

_____

How would you describe your recent mood? Is this normal for you? _____

_____

Any previous mental health treatment? (Outpatient, Inpatient, and/or Emergency Hospitalizations) Yes No
(Please circle)

Name of Provider/Agency	Dates of treatment
_____	_____
_____	_____
_____	_____

What did you like/not like about your previous experiences with mental health treatment? (if applicable)

_____

_____

_____

Has anyone in your family ever been treated for mental health issues? _____

_____

Have you ever taken or are you currently taking psychiatric medication? Yes No (Please circle)

Name of Medication	Dosage
_____	_____
_____	_____
_____	_____

Current medical medications (include all names & dosages):

_____

_____

Do you have any questions about therapy or anything else I can answer? _____

_____

_____

How did you hear about my services? _____

_____

_____ _____

Print Name/Date Leslie Hannon, Psy.D./Date
Licensed Clinical Psychologist