James & Brick Associates

General Information Form

302-655-8101

Client Name: _____
Last Name First Name

DOB: _____

Address: _____

_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ (Okay to be contacted at work?) Yes No

Please list the people who live in your home and their relationship to you:

_____

_____

***If under 18 years of age:**

Parent/Guardian's name(s): _____

Address (if different than yours): _____

_____

Home Phone (if different than yours): _____

School you attend: _____ Grade: _____

Primary care physician and/or other treatment providers:

_____

Have you ever been in therapy before? Yes No

If so: When? _____

With Whom?_____

Please list any medications or supplements that you take & how long you have been taking them:

_____

_____

_____

Approximately how many hours do you sleep each night? _____

Do you ever experienced sleep disturbance? **Yes** **No**

If so please describe: _____

_____

_____

Please describe your level of physical activity and the frequency of any exercise you may do:

_____

_____

Please describe your eating habits, including what you eat for breakfast, lunch, & dinner, & when you eat these meals. Please also note what you eat for snacks, & when you eat them:

_____

_____

_____

_____

Who is responsible for payment? _____

Today's date: _____