Claudette C. Granahan, Ph.D.
Licensed Clinical Psychologist

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Client Information Questionnaire
Please Print Clearly

Today's Date: ____________________________

Name: ____

Date of Birth: _______________________________________

Address: ____

____

Tel. Home: _____________________ Work: _______________ Cell: _______________

Okay to leave messages? Home: _______ Work: __________ Cell: _______________

Employer: ______________________________ Position: ________________________

Highest Level of Education: ____

Please list any medical conditions: ____

Please list any medications you are currently taking and any past psychiatric, anti-seizure, or pain medications:

Emergency Contact:

Name: ______________________________________ Telephone: __________________

Please proceed to the second page.

Insurance Information:

Name of Insurance Company and Program:

____

Their Telephone Number: __________________Your ID Number:_______________

If the policy is not in your name, please provide information about the policy holder:

Name:____

Date of Birth:______________ Employer:___________________________

Address:____

____

Primary Care Physician Information:

Name of Clinic, Practice, or Facility, if applicable:________________________

Physician Name:_______________________________Tel.:______________

By signing here, the client named above authorizes Claudette C. Granahan, Ph.D., to contact the primary care physician to coordinate treatment as necessary. This document constitutes an authorization for release of information. *If document is unsigned, the client indicates that he or she does not wish for information to be exchanged.*

Signature:____________________________________Date:___________________

Witness:____

Thank you for taking the time to provide this information. It will help in preparing better and more specific treatment for you.