Keely Kolmes, Psy.D. **CA License: PSY21284**

Confidential Client Information Form

Contact Information

Date:

Name:

Street Address: OK to send mail?

City/State/Zip: ☐ Yes ☐ No

D.O.B./place:

	OK to call?		OK to leave message?	
Home phone:	☐ Yes	☐ No	☐ Yes	☐ No
Cell phone:	☐ Yes	☐ No	☐ Yes	☐ No
Work phone:	☐ Yes	☐ No	☐ Yes	☐ No

	OK to email?	
Email:	☐ Yes	☐ No

Please provide a password that only you and I will know so that I can send you encrypted email (for anything other than scheduling changes):

Please provide a name and phone number of whom to call in case of an emergency:

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Receipt Information

Will you be requesting a bill? If yes, please choose one:

☐ Bill is for insurance (requires a diagnosis, and we will discuss this).

☐ Bill is for flex spending (no diagnosis required).

Demographic Information

Sex:

Gender:

Preferred Gender Pronoun(s):

Sexual Orientation(s):

Ethnicity:

Disability Status:

Partner(s)/relationship Status:

Occupation / Employer:

Referral Information

Who referred you to me or how did you hear of my practice?

Current reason(s) for seeking therapy:

Keely Kolmes, Psy.D. 220 Montgomery Street, Suite 400 San Francisco, CA 94104 (415) 501-9098
Website: http://drkkolmes.com Email: drkkolmes@hushmail.com

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Estimate the severity of the problem for which you are seeking care:

☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

How many sessions or how much time do you think you might need to successfully resolve this problem?

☐ 1 – 10 sessions ☐ 20 or more sessions

☐ 10 – 20 sessions ☐ ongoing, longer-term therapy

Health Information

Have you ever been hospitalized? (If yes, please provide details):

Are you currently taking any medications? (Please list names, dosages, and prescribing doctor.):

Have you previously been in psychotherapy?

When and for what issues?

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Was it helpful? (Why or why not?)

Do you have any previous suicide attempts, self-destructive behaviors, or violent behaviors? (Indicate age, circumstances, and whether it led to hospitalization or legal problems).

Please list any past/present drug and alcohol use. What have you used and how much? What are you currently using and how much? Has it ever affected your work or your relationships?

Relationships

Do you live with others? What is their relationship to you?

Present Spouse/Partner(s) (first name(s), occupation(s), how would you describe your relationship satisfaction?):

Are there any other current relationships that are a significant focus in your life right now? Please describe:

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Other

What are your main worries or fears?

What do you consider your main strengths?

What are your primary challenges right now?

What are your most important hopes or dreams?

Please add any additional information that may be helpful to our work together.

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Follow Up

To help me continue my development as a clinician, I send a brief survey to clients 4-6 weeks after they have ended treatment with me.

Completing this form is optional and anonymous. Please choose one of the following:

☐ Please email me the link to the form. I understand that I can decide at that time whether or not I wish to complete it.

☐ Please opt me out of receiving this form. I do not wish to receive it.

I am also interested in whether you are able to maintain your treatment goals when you complete therapy with me. I would like to send a brief form to check in with you a year after you finish treatment.

Please choose one:

☐ You are welcome to contact me one year after I complete therapy to check in on how I am doing. I understand that I can decide at that time whether or not I wish to respond.

☐ Please opt me out of the one-year follow up.

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