

# Dr. Pilar Jennings

*Licensed Psychoanalyst*

## CONFIDENTIAL PATIENT INFORMATION

*Please answer the following questions as completely as possible.  
Be sure to bring to my attention any question that causes you concern  
or that you would prefer to discuss in person.*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Email: \_\_\_\_\_

Home phone: ( ) \_\_\_\_\_ May I leave messages there?  yes  no

Work phone: ( ) \_\_\_\_\_ May I leave messages there?  yes  no

Cell phone: ( ) \_\_\_\_\_ May I leave messages there?  yes  no

Age: \_\_\_\_\_ Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Place of birth: \_\_\_\_\_

Reason for Therapy:

*(briefly describe your reasons for seeking therapy)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Employment status:  Full time  Part time  Not employed

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Highest educational degree obtained: \_\_\_\_\_

Field of study: \_\_\_\_\_

If currently a student: Year/class: \_\_\_\_\_ School: \_\_\_\_\_

Relationship status:  Single  Partnered/married  Coupled but not living together  
 Separated  Divorced  Widowed/bereaved

Significant other: Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Current living situation (for example, alone, with partner, with roommates, with family or extended family):  
\_\_\_\_\_  
\_\_\_\_\_

Previous relationships you consider significant:  
\_\_\_\_\_  
\_\_\_\_\_

Children: Name: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Name: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Name: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Name: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Parents: Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Were you adopted?  yes  no

Were you raised by:  both parents  mother  father  other: \_\_\_\_\_

Are your parents still alive and their marital status? : \_\_\_\_\_  
\_\_\_\_\_

Siblings: (*in birth order*)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

In your family or your own history, have there been any of the following:

alcoholism or substance abuse

mental illness

physical abuse

sexual inappropriateness or abuse

economic hardship

medical illness or surgeries

accidents

repeated losses

bullying or other harassment

other overwhelming circumstances that affected how you grew up, or how you function now?

We can discuss the above issues in person, or you may note them here, in a few words, for us to come back to if and when you would like us to work with them:

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Medical conditions: *(please list all known medical conditions)*

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Medications: *(please list current medications)*

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Personal physician:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

May I speak with your physician if necessary?  yes  no

Psychiatrist or psychopharmacologist (if you have one):

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

May I speak with your psychiatrist or psychopharmacologist?  yes  no

Have you had previous individual or group psychotherapy or counseling?  yes  no

Clinician's name: \_\_\_\_\_ Sessions from \_\_\_\_\_ to \_\_\_\_\_.

Have you even been hospitalized for substance abuse, alcoholism, eating disorders, or other psychiatric disorders?  yes  no. Details:

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Referred by \_\_\_\_\_

Emergency contacts:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Confidentiality statement**

What you have disclosed to me on this form, and what we discuss in therapy, are confidential matters. This means that what you say will not be talked about with anyone else. There are certain exceptions to this, which are 1) if you are in danger to yourself (i.e., suicidal); 2) if you are a danger to others; 3) if you disclose the identity of a minor who has ever been abused physically, sexually, or mentally; 4) if you are involved in a legal matter and I am required to comply with the demands of the court; or 5) when I consult with colleagues about my work in order to assure my clients the best possible care. The first four situations are extremely rare. The fifth is more common, but be assured that during such consultations, I make every effort to avoid revealing the identity of patients, and the colleagues with whom I may consult are also legally bound to keep the information confidential.

**Your agreement**

*If you are comfortable signing the following statement, please do so. If you have any questions or concerns about it, we will want to address them during our initial meeting.*

I, \_\_\_\_\_, agree to be responsible for professional fees incurred during the course of psychoanalysis with Dr. Jennings, which includes fees for all individual appointments (unless canceled 48 hours in advance). I will make payment at the time of the appointment unless an alternative agreement has been made. If I seek insurance reimbursement for services, I may ask Dr. Jennings to furnish any additional information required to process my claim, but I understand that payment for services is my responsibility and separate from any reimbursement I may receive from my insurance company.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_