UNIVERSITY of VIRGINIA
SCHOOL of EDUCATION and HUMAN DEVELOPMENT
Sheila C. Johnson Center

Sheila C. Johnson Center
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1. Download form to your computer desktop.
2. Open form with Adobe Reader, available at https://acrobat.adobe.com/us/en/acrobat/pdf-reader.html
3. Save form after filling in the fields.
4. Return form via OnPatient

CLIENT HISTORY

Client's Name: _____ Today's Date: _____

Date of Birth: _____ Age:_____ Ethnicity:_____

Gender: ☐ Female ☐ Male ☐ Non-Binary/third gender ☐ Prefer not to say ☐ Self-Describe_____

Gender as it is related to your insurance policy: ☐ Female ☐ Male

Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Parent/Guardian (if client is child):_____ Age: _____

Address (if different): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Highest Level of Education: _____

Relationship to client: _____

Parent/Guardian (if client is child):_____ Age: _____

Address (if different): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Highest Level of Education: _____

Relationship to client: _____

Additional individuals living in household:

Name	Relationship	Age	Name	Relationship	Age

REASON FOR VISIT

What services are you seeking? ☐ Clinical Psychology Services ☐ Counseling Services ☐ Audiology Services ☐ McGuffey Reading Services ☐ Speech-Language Services

Briefly state your reason(s) for seeking services:

_____

_____

By whom were you referred: _____

Have you had services like this before? ☐ Yes ☐ No

When? _____

Where? _____

HISTORY

Client currently attends: ☐ daycare ☐ elementary school ☐ middle school ☐ high school ☐ college/university ☐ none

Where: _____

Has the client ever in the past received special help or accommodations at school or work? ☐ Yes ☐ No

If so, please explain: _____

_____

Has client received any diagnoses related to learning, mental health, communication, etc.? ☐ Yes ☐ No

If so, please explain: _____

_____

*** If the client has received any previous evaluations for learning, mental health or communication concerns please provide copies**

MEDICAL

Primary Physician or Pediatrician: _____ Phone: _____

Date of last visit: _____

Does the client have any chronic illnesses, current health problems and/or medical diagnoses? ☐ Yes ☐ No

If yes, please describe: _____

Is the client currently taking prescription or non-prescription medications? ☐ Yes ☐ No

If yes, please list medication(s), problem(s) being treated, and prescribing physician(s): _____

_____

Does the client have any known allergies? ☐ Yes ☐ No

If yes, please indicate): _____

Is there any family history of significant health problems? ☐ Yes ☐ No

If yes, please describe: _____

_____

Name of person completing this form: Signature: ☐ Check Box to Sign

Relationship to client (if applicable): Date:

If you do not have access to a digital signature, please check the box as an indication that you have read and understand this document.

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship: _____ Phone number: _____

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