

**Basic Information Form**  
**Robley K. Yee, PhD, LICSW**

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance # \_\_\_\_\_

Home Phone (    ) \_\_\_\_\_ Cell (    ) \_\_\_\_\_ Work (    ) \_\_\_\_\_

Billing Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Highest Level of Education \_\_\_\_\_ Profession: \_\_\_\_\_

Job History \_\_\_\_\_

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Spouse's/Partner's Name \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Race/Culture \_\_\_\_\_

Highest Level of Education \_\_\_\_\_ Profession \_\_\_\_\_

Marital/Relationship History \_\_\_\_\_

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Please list children, their ages, and where they reside: \_\_\_\_\_

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Previous therapy experience: \_\_\_\_\_

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What do you see as your chief reason for coming to therapy? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any legal matters currently pending: \_\_\_\_\_  
\_\_\_\_\_

Health Problems (please list): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Ever lost consciousness and why?: \_\_\_\_\_

Do you exercise? If so, how often and what type of regular physical activity do you do?:  
\_\_\_\_\_  
\_\_\_\_\_

Alcohol and/or substance use history (describe use history, age of first use, frequency, amounts):  
\_\_\_\_\_  
\_\_\_\_\_

Suicide/self-harm/harming others (describe any history of these types of issues):  
\_\_\_\_\_  
\_\_\_\_\_

Medications: \_\_\_\_\_  
\_\_\_\_\_

Family of Origin (please list siblings and parents, their ages or if deceased when and one work to describe your relationship with each):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Spiritual/Religious Orientation: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_  
Relationship / Number \_\_\_\_\_