**ADULT PATIENT INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date: Account No.: Dx:** | | | | |
| **Adult Patient Information** | | | | |
| Last Name: | | First Name: | | Nickname: |
| Birthdate: / / | | Age: | | Gender: |
| Marital Status: □ Single □ Separated □ Divorced □ Married | | | | Languages spoken at home: |
| Street Address: | | City: | | State: Zip Code: |
| Home Phone: | | Cell phone: | | Best number to leave messages: |
| Have you or a family member been seen by Dr. Pender before? Y or N | | | | |
| **Referral Information** | | | | |
| Referred by:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | How did you learn about this practice: □ Doctor □ Lawyer □ Friend □ School  □ Co-worker □ Internet search □ Presentation/Talk □ Marketing □ Other | | | |
| **Employment Information** | | | | |
| Occupation: | | | | Employer: |
| Number of years at current position: | | | | Highest Level of Education: |
| **Spouse/Partner Information (if applicable)** | | | | |
|  | |  | | |
| Name | |  | | |
| Age | |  | | |
| Highest Education Level | |  | | |
| Occupation | |  | | |
| Employer | |  | | |
| Cell Phone | |  | | |
| Work Phone | |  | | |
| Home Phone (if different from patient) | |  | | |
| Email Address | |  | | |
| Address (if different from patient) | |  | | |
| **Children (please list)** | | | | |
| Names: 1- | Gender : Age: | | □ Biological □ Step □ Adopted | |
| 2- | Gender : Age: | | □ Biological □ Step □ Adopted | |
| 3- | Gender : Age: | | □ Biological □ Step □ Adopted | |
| 4- | Gender : Age: | | □ Biological □ Step □ Adopted | |
| **Medical Information** |  | |  | |
| Doctor: Phone: Fax: | | | | |
| Street Address: | City: | | | State: Zip Code: |
| Medical Problems (list): | | | | |
| Allergies: | | | | |
| Hospitalizations/Surgeries: | | | | |
| Medication Name: Dosage: X per day: Reason: | | | | |
| Medication Name: Dosage: X per day: Reason: | | | | |
| Medication Name: Dosage: X per day: Reason: | | | | |
| **Mental Health History** | | | | |
| Mental Health Diagnoses: | | | | |
| Previous Professionals Seen: Name(s): Date(s): | | | | |
| Previous Evaluations: □ Psychological □ Educational □ Speech and Language □ Occupational Therapy  □ Neuropsychological □ Emotional □ Behavioral | | | | |
| **Family Stressors** | | | | |
| □ Abuse □ Deaths □ Job □ Relocation □ Stepchildren □ Trauma  □ Births □ Divorce □ Marriage □ School □ Substance Use □ Other(s):  □ Bullying □ Finances □ Medical □ Separation □ Substance Abuse | | | | |
| **Family Strengths** | | | | |
| Please Describe: | | | | |
| **Reason For Seeking Help At This Time:** | | | | |
| Please Describe: | | | | |
| **Financial Matters** | | | | |
| Who is responsible for payment of services? | | | | |
| If the responsible party is someone other than yourself, it is often easiest to ask this person to sign an authorization form to allow their credit card be used each session. Please discuss the Business Policy and Agreement and Authorization for credit card use with this person and return these forms along with the Financial Responsibility form. ***I understand that I give my permission to discuss financial matters with my parents if they are paying for treatment.*** | | | | |
| Signature: Date: | | | | |