BASIC IDENTIFYING INFORMATION - FAMILY PSYCHOLOGY ASSOCIATES, PC

Patient Name ______________________________ Date of Birth ______________

Address ______________________________ City/State __________ Zip ________

Home Phone ______________ Regular Physician(s) ______________________________

Additional Contact Information: Cell phone numbers / Whose phone is this (mother/father/stepparent/etc.)?

______________ ______________________________

______________ ______________________________

Who referred you here? ______________________________

Mother's Name ______________________________ Date of Birth ______________

Mother's Employer ______________________________ Mother's Work Phone ______________

Father's Name ______________________________ Date of Birth ______________

Father's Employer ______________________________ Father's Work Phone ______________

Who Has Custody of Child (If not both parents) ______________________________

School ______________ Grade ______ Special Education Services? ______ If yes, what type?______

Teacher(s) ______________________________

Previous History of Psychological and/or Psychiatric Services:

Please list any previous history of counseling, psychological, or psychiatric services (i.e. individual or family counseling, psychological evaluation, psychiatric medication). Please name all providers and approximate dates seen:

____

____

Please list any medications now or previously taken for behavioral, emotional, or psychiatric difficulties:

Current medication(s) and dosages (if known) ______________ Prescribed by ______________

______________ Prescribed by ______________

______________ Prescribed by ______________

______________ Prescribed by ______________

Past medication(s) and dosages (if known) ______________ Prescribed by ______________

______________ Prescribed by ______________

______________ Prescribed by ______________

Please read the attached statements regarding Confidentiality and Payment for Services Rendered. Please sign below acknowledging that you have sought psychological services from Family Psychology Associates, PC, that you have been provided with this office's Notice of Privacy Practices, and that you agree to our Notice of Payment Policies.

______________________________ ______________

Signature Relationship to child Date