The Psychological Health Collaborative, PLLC

Adult Background Form

Today's Date:_____

Name: _____ DOB:_____

Address: Sex: Male Female

_____

(Street/Apartment) (City) (State) (Zip)

Home Phone: (_____)_____ Cell Phone: (_____)_____

Work Phone: (_____)_____ Other Phone: (_____)_____

*Please indicate where we may leave you a voicemail with an asterisk**

E-mail Address:_____

Occupation/Place of Business:_____

Highest Level of Education Achieved & Date of Completion:_____

Religion: _____ Ethnicity: _____

With whom do you reside? Please indicate relation: spouse, children, parents, room-mate, etc. _____

(This information is requested in the event that your doctor must call you at home. No information will be given to anyone regarding your appointments without your written permission. Please specify with whom and at what phone number we may leave a message:
_____)

Referral Source:

Doctor_____
(Name) (Address) (Phone)
Friend or relative_____
Other (please specify)_____

In Case of Emergency Contact:

Name: _____ Relationship to you: _____
Phone Number(s): _____

Marital Status (circle one):

Never Married Married (Date: _____) Separated
Engaged Divorced (Date: _____) Widow(er)
Spouse's Name: _____

Children

Name Date of Birth Where Resides

_____

_____

_____

_____

_____

_____

Please describe any known health problems, medical problems, medical issues, past hospitalizations, surgeries, developmental problems, etc. for yourself:

_____

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Please describe any significant mental or physical health issues of family members (parents, siblings, grandparents, aunts, uncles, children, spouse, etc.)

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Current/Previous Psychological Evaluations and Treatments:

Name of Doctor, Agency, Hospital, etc.	City, State	Date(s)	Briefly explain services provided and outcome

Additional information not previously mentioned:

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