THERAPY DALLAS

Psychological Services for Children, Adolescents, and Adults
12800 Hillcrest A124, Dallas, TX 75230 • 214-755-6119 • www.therapydallas.com

GENERAL INFORMATION

Date: _____

PATIENT:

Name, Age: _____, _____
Address: _____
_____
Occupation: _____
Highest Grade/Degree: _____

Birthdate: _____
E-mail: _____
Phones: (cell) _____ msg ok ☐
(home) _____ msg ok ☐
(work) _____ msg ok ☐

Marital status: ☐ never married ☐ married ☐ partnered ☐ separated ☐ divorced

FAMILY:

Spouse: Name, Age: _____, _____
Occupation: _____
Highest Grade/Degree: _____
Children: Name, Age: _____, _____
Name, Age: _____, _____
Name, Age: _____, _____
Others Living in Home: _____

Mother: Name, Age: _____, _____
Occupation: _____
Highest Grade/Degree: _____
Father: Name, Age: _____, _____
Occupation: _____
Highest Grade/Degree: _____

OTHER HEALTH/SERVICE PROVIDERS (e.g., Primary Care Physician, Psychiatrist, etc.):

Name: _____ Provider Role: _____ Phone: _____
Address: _____

Name: _____ Provider Role: _____ Phone: _____
Address: _____

EMERGENCY CONTACT(S):

Name: _____ Relationship to Patient: _____ Phone: _____
Address: _____

Name: _____ Relationship to Patient: _____ Phone: _____
Address: _____

REFERRAL SOURCE:

Referred by: _____ Phone: _____
Consent to acknowledge the referral? ☐ Yes ☐ No