**Silber Psychological Services, P.A.**

www.silberpsych.com

|  |  |
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| 1004 Dresser Court, Suite 103 | 1340 S.E. Maynard Road, Suite 201 |
| Raleigh, North Carolina 27609 | Cary, North Carolina 27511 |
| Telephone: (919) 876-5658 | Telephone: (919) 481-9012 |
| Facsimile: (919)-790-1521 | Facsimile: (919)-481-9013 |

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| Date of Appointment: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Dx: | \_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | *for office use only* |  |  |
| Acct. Number | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Tx: | \_\_\_\_\_\_\_\_\_\_\_\_ |

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| PATIENT INFORMATION for Adults | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Name | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
|  | | | | | | | | | | *First* | | | | | | | | | | | *M* | | | | | | | | | | |  | | | | | *Last* | | | | | | |  | | | | | *Name you prefer to go by* | | | | | | | | | | | | |
| Address: | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | *Street* | | | | | | | | | | | | |  | |  | | | | | | | | | | | *City* | | | | |  | | | | | |  | | | | *State* | | | | | |  | | | *Zip* | | | | | | |
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| Home Phone Number: | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | Cell Phone Number: | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | Work Number: | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
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| Sex: | | \_\_\_\_\_\_\_ | | | | | | | Age: | | | | | | \_\_\_\_\_\_ | | | | | | Birthdate: | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | Highest Education Level: | | | | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
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| Marital Status: | | | | | | | | | | | | * Single | | | | | | | | | | | | | | | * Married | | | | | | | | | | | | | | * Separated | | | | | | | | | | | | | * Divorced | | | | | | | |
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| Have you been seen here at this office before? | | | | | | | | | | | | | | | | | | | | | | | | | | | | * Yes | | | | | | | | | | * No | | | | | | | | | | | | | | | | | | | | | | | |
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| Primary E-Mail Address: | | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Employer (if employed): | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| REFERRAL INFORMATION: | | | | | | | | | | | | | | | | |
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| Referred by: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
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| How did you hear about our practice? (Check all that apply) | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| * Your doctor | | | | * Friend | | * Therapist | | * Internet Search | | | * Phonebook / Yellow Pages | | | | | |
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| * Other: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |

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| SPOUSE INFORMATION(if applicable): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Name | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | *First* | | | | | | | *M* | | | | | | | | |  | | | | | *Last* | | | | |  | | | | | | | |  | | | | | |
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| Address (if same indicate *“same”*): | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | *Street* | | | | | | | | | *City* | | | | | | | | | | | | | *State* | | | | | | | *Zip* | | | | |
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| Home Phone Number: | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | Cell Phone Number: | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | Work Number: | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
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| Sex: | | \_\_\_\_\_\_\_ | | | | | | | | | | | Age: | | | | \_\_\_\_\_\_\_ | | | | | | | Birthdate: | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |  |
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| Has your spouse been seen at this office before? | | | | | | | | | | | | | | | | | | |  | | | | * Yes | | | | | | |  | * No | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | |
| Highest Education Level | | | | | | | | | \_\_\_\_\_\_\_\_\_\_ | | | | | | Employer (if employed): | | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |
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| FAMILY INFORMATION If you have children please list their names and age (if none indicate “none”) | | | |
|  | name | age |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| MEDICAL INFORMATION: | | | | | | | | | | | | | | |
| Primary Care Physician: | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Name of Practice: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  | |  | | | | | | | | | | | |
| Address: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
|  | | *Street* | | | | | | | *City* | | *State* | | Zip |
|  | | | |  | | | | | | | | | |
| Phone Number: | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
|  | | | |  | | | | | | | | | |
| Medical Problems (if none indicate *“none”*)*:* | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
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| Allergies (if none indicate *“none”*) | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
|  | |  | | | | | | | | | | | |
| Hospitalizations/Surgeries (if none indicate *“none”*)*:* | | | | | | | | | | | | Date / Year | |
|  | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| Please list any medications that you are currently taking (if none indicate *“none”*)*:* | | | | | | | |
|  |  | Name of Medication | Units | Frequency | Prescribing Doctor | Date Started |
|  |  |  |  |  |  |  |
|  | 1. | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |
|  | 2. | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |
|  | 3. | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ |

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| PRIOR PROFESSIONAL HELP |
|  |
| Please list names of providers and approximate dates (if none indicate *“none”*): |
|  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| STRESSORS AFFECTING YOU IN THE PAST 1-2 YEARS |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| * Births | | * Job Change | | * Separation | * Financial Issues |
| * Deaths | | * Relocation | | * Divorce | * Physical/Sexual Abuse |
| * Trauma | | * School | | * Marriage | * Substance Abuse |
| * Medical | | * Bullying | | * Stepchildren |  |
|  | | |  | | |
| * Other (Please list): | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

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| MAIN PROBLEM OR REASON FOR SEEKING HELP |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I understand that I am financially responsible for all of my services. If someone else agrees to be responsible for payments, I will have that person complete and submit a Financial Responsibility form. I recognize that I am still responsible for seeing that each session is paid in full.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_