

Silber Psychological Services, P.A.

www.silberpsych.com

1004 Dresser Court, Suite 103
Raleigh, North Carolina 27609
Telephone: (919) 876-5658
Facsimile: (919)-790-1521

1340 S.E. Maynard Road, Suite 201
Cary, North Carolina 27511
Telephone: (919) 481-9012
E-Mail: info@silberpsych.com

Date of Appointment: _____ *for office use only* Tx: _____

Patient Information for Adults

Name: _____
First MI Last Name you prefer to go by

Addresses: _____
Street City State Zip

Home Phone Number.: _____ Cell Number: _____ Work Number.: _____

Age: _____ Birthdate: _____ Highest Education Level: _____

Sex assigned at birth: Male Female

Gender Identity: _____

Marital Status: Single Married Separated Divorced

Have you been seen here at this office before? Yes No

Primary E-Mail Address: _____

Occupation: _____ Employer (if employed): _____

Referral Information

Referred by: _____

How did you hear about our practice? (Check all that apply)

Friend Your doctor Therapist Internet Search Phonebook / Yellow Pages

Other: _____

Spouse Information (if applicable):

Name: _____
First M Last

Address (if same indicate "same"): _____
Street City State Zip

Home Phone Number: _____ Cell Phone Number: _____ Work Number: _____

Sex: _____ Age: _____ Birthdate: _____ Highest Education Level: _____

Has your spouse been seen at this office before? Yes No

Occupation: _____ Employer (if employed): _____

If you have children please list their names (if none indicate "none") : _____ and their age:



Medical Information

Primary Care Physician: _____ Name of Practice: _____

Address: _____
Street City State Zip

Phone Number: _____

Medical Problems (if none indicate "none"): _____

Allergies (if none indicate "none") _____

Hospitalizations/Surgeries (if none indicate "none"): _____ Date / Year

Please list any medications that you are currently taking (if none indicate "none"):

	Medication	Dosage	# per day	Approximate date started
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Prior Professional Help Please list names of providers and approximate dates (if none indicate "none"):

Please check any the following stressors affecting your family in the past 1-2years (Check all that apply):

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

Main problem or reason for seeking help:

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: _____