Silber Psychological Services, P.A.

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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 College Students*

Name _____ _____
First *M* *Last* *Name you prefer to go by*

Address: _____
Street *City* *State* *Zip*

Sex assigned at birth: ☐ Male ☐ Female Age: _____ Birthdate: _____

Gender Identity: _____

Primary Phone Number: _____ Have you been seen here at this office before? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

Primary E-Mail Address: _____

Employer (if employed): _____ Work Number: _____

SCHOOL INFORMATION:

School Currently Attending: _____ Current year in school _____

Major or field of study: _____

REFERRAL INFORMATION:

Referred by: _____

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

☐ Your doctor ☐ Friend ☐ Therapist ☐ Internet Search ☐ Phonebook / Yellow Pages

☐ Other: _____

SIBLINGS AND OR FAMILY INFORMATION:

If you have siblings or children please list their relationship to you (S) Sibling or (C) Child and their name , age (if none indicate *"none"*)

_____ _____

_____ _____

SPOUSE INFORMATION (*IF* applicable if not please indicate "none"):

Name: _____
First *M* *Last* *Age*

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

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

PARENT INFORMATION	PARENT 1	PARENT 2
1. Name:	1._____	1._____
2. Relationship to Patient	2. _____	2._____
3. Age: 4. Highest Education Level:	3._____ 4. _____	3._____ 4._____
5. Occupation:	5._____	5._____
6. Place of Employment:	6._____	6._____
7. Work Phone Number:	7._____	7._____
8. Cell Phone Number:	8._____	8._____
9. Home Phone Number, ***if*** different from child:	9._____	9._____
10. Address, ***if*** different from child:	10. _____	10. _____
	_____	_____

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CAREGIVER (continued)	STEP-PARENT 1	STEP-PARENT 2
1. Name:	1._____	1._____
2. Relationship to Patient	2. _____	2._____
3. Age: 4. Highest Education Level:	3._____ 4. _____	3._____ 4._____
5. Occupation:	5._____	5._____
6. Place of Employment:	6._____	6._____
7. Work Phone Number:	7._____	7._____
8. Cell Phone Number:	8._____	8._____
9. Home Phone Number, ***if*** different from child:	9._____	9._____
10. Address, ***if*** different from child:	10. _____	10. _____
	_____	_____

MEDICAL INFORMATION:

Primary Care Physician: _____ Name of Practice: _____

Address: _____ Phone Number _____
Street *City* *State* Zip

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"*):

	Name of Medication	Units	Frequency	Prescribing Doctor	Date Started
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

PRIOR PROFESSIONAL HELP: (Please list the names of other providers you have seen and approximate dates, *IF* none Indicate "none")

_____

_____

STRESSORS AFFECTING YOUR FAMILY IN THE PAST 1-2years:

☐ Births	☐ Job Change	☐ Separation	☐ Financial Issues
☐ Deaths	☐ Relocation	☐ Divorce	☐ Physical/Sexual Abuse
☐ Trauma	☐ School	☐ Marriage	☐ Substance Abuse
☐ Medical	☐ Bullying	☐ Stepchildren	

☐ Other (Please list): _____

MAIN PROBLEM OR REASON FOR SEEKING HELP:

_____

_____

_____

FINANCIAL MATTERS: Who will be financially responsible for any services?

☐ Myself ☐ Father ☐ Mother ☐ Other Individual: _____

If the responsible party is someone other than yourself, it is often easiest for them, you, and our office to have them sign an authorization to let their credit card be used each session. Please discuss the Business Policy and Agreement and Authorization for Credit Card use with them, and return these and the Financial Responsibility forms signed by one of your parents. I understand that I give my permission to discuss financial matters with my parents if they are paying for treatment.

Signature: _____ Date: _____