Silber Psychological Services, P.A.

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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:

____ ____________

____ ____________

____ ____________

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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"*): ____

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: ________________________