

**ADULT INFORMATION FORM**  
**WESTERN PSYCHOLOGICAL AND COUNSELING SERVICES, P.C.**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Gender: M\_\_\_F\_\_\_ Age: \_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_/\_\_\_/\_\_\_

Client number: \_\_\_\_\_ SSN: \_\_\_/\_\_\_/\_\_\_  
Employer group of Insured Person: \_\_\_\_\_

**CONTACT TELEPHONE NUMBERS**

Please complete relevant information and indicate the number at which you wish to be contacted first.

<b>PHONE NUMBERS</b>	<b>OK to leave Messages?</b>	<b>Primary contact number?</b>
	YES NO	
<b>HOME:</b> (    ) _____	___ ___	___
<b>WORK:</b> (    ) _____	___ ___	___
<b>CELL:</b> (    ) _____	___ ___	___

**MARITAL STATUS**

\_\_\_ **SINGLE**    \_\_\_ **DIVORCED** (\_\_\_) YRS    \_\_\_ **LIVING AS MARRIED** (\_\_\_) YRS  
\_\_\_ **MARRIED** (\_\_\_) YRS    \_\_\_ **SEPARATED** (\_\_\_) YRS    \_\_\_ **WIDOWED** (\_\_\_) YRS

**SPOUSE/PARTNER NAME:** \_\_\_\_\_

If WPCS is unable to reach you, is it OK to contact your spouse/partner? Yes\_\_\_ No\_\_\_

If yes, spouse/partner phone number: (    ) \_\_\_\_\_

**EMPLOYMENT STATUS**

**Are you employed:** \_\_\_ Yes \_\_\_ No

**Employer Name:** \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: (    ) \_\_\_\_\_ Relationship to you: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN**

Current Physician: \_\_\_\_\_  
Physician Address: \_\_\_\_\_  
Physician Phone Number: (    ) \_\_\_\_\_  
Physician Fax Number: (    ) \_\_\_\_\_

**REFERENT INFORMATION**

**BY WHOM WERE YOU REFERRED?** \_\_\_\_\_

PHONE: (    ) \_\_\_\_\_ FAX: (    ) \_\_\_\_\_

**PRESENTING PROBLEM:** \_\_\_\_\_