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

Name: ___________________________________ Date: ____________________
Address: _________________________________ Gender: M___F___ Age: ___
_________________________________ Date of Birth: ___/___/______
City: ________________ State: ________ Zip: ________________

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.

PHONE NUMBERS	**OK** to leave Messages? YES	NO	**Primary contact** number?
HOME: ( ) ______________________	___	___	___
WORK: ( ) ______________________	___	___	___
CELL: ( ) ______________________	___	___	___

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: ____
Staff Signature: _______________________________________ **Date:** ____________________