WASHINGTON PSYCHOLOGICAL CENTER, P.C.

(PLEASE PRINT)

NAME: AGE:
LAST FIRST MIDDLE

NAME YOU WISH TO BE CALLED BY: DATE OF BIRTH:

ADDRESS: TELEPHONE

ZIP: HOME

E-MAIL ADDRESS: OFFICE

REFERRED BY:

SEX: RELATIONSHIP STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Significant Other

OCCUPATION: INSURANCE CO:

EMPLOYED BY: SUBSCRIBER NO:

ADDRESS: GROUP NO.:

SIGNATURE: TODAY'S DATE
PATIENT OR LEGALLY RESPONSIBLE PARTY

FAMILY INFORMATION:	**AGE**	**DECEASED DATE**	**OCCUPATION**	**EDUCATION**	**STATE OF HEALTH**
FATHER					
MOTHER					
STEP-FATHER					
STEP-MOTHER					
BROTHERS/SISTERS (Circle Sex)					
M F					
M F					
M F					
M F					
M F					
SPOUSE/PARTNER M F					
SONS/DAUGHTERS M F					
M F					
M F					
M F					
M F					

EDUCATION: HIGHEST DEGREE:

WHERE OBTAINED:

HEALTH:

a. How would you describe your general health?

b. What medication, if any, are you taking presently? For what condition(s)?

c. When was your last physical examination?

d. Name and phone number of your physician:

e. Please list any noteworthy physical problems:

(OVER)

BRIEF (1-2 Sentences) DESCRIPTION OF PROBLEM FOR WHICH YOU ARE SEEKING HELP:

GOALS FOR THERAPY:

PREVIOUS PSYCHOTHERAPY/COUNSELING:

a. Therapist's Name and Address:

☐ Individual ☐ Group ☐ Couple/Family

Duration of Treatment: From To Session Frequency/Week:

b. Therapist's Name and Address:

☐ Individual ☐ Group ☐ Couple/Family

Duration of Treatment: From To Session Frequency/Week:

History of Hospitalizations:

a. Hospital Dates:

Reason:

b. Hospital: Dates:

Reason:

SPECIAL INTERESTS/HOBBIES: (Please Describe)