

Psychological Testing Consultants Face Sheet

Confidential

Date: _____ Acct. #: _____

Patient Name: _____ SSN: _____ - _____ - _____
Last First M.I.

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Email: _____

Gender: Male Female Date of Birth: _____ - _____ - _____ Age: _____

Marital Status: Married Single Divorced
 Separated Widowed NA (children)

Employment Status: employed student
 employed/student unemployed

Employer: _____

Insurance Company: _____

Insurance Company: _____

Referral Source: _____

Referral Type: self family spouse friend
 clergy EAP work court
 school other _____

Primary Care Physician: _____ Phone: _____

Residence Situation: Private Household Group Home
 Nursing Home Other Residential Facility
 Homeless Shelter Jail or Correctional Setting

Educational Level (Highest Grade Completed): _____
 less than high school some college
 some high school college graduate
 high school graduate post-graduate work

Military Service: No If Yes, Status:
 Yes Active Honorable Discharge
 Medical Discharge Dishonorable Discharge

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Religion (optional): Catholic Protestant
 Jewish Moslem
 Hindu Other

Race (optional): White African-American
 Hispanic Native American
 Asian-American Other

In Case of Emergency, Contact:

Name: _____ Relationship: _____
Phone: _____

If patient is minor:

Mother (or Guardian) Father

Name: _____

Address: _____

(Cell) Phone: _____

(Email): _____

Additional Information: