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 <u>If Yes, Status:</u>
[ ] Yes [ ] Active [ ] Honorable Discharge
[ ] Medical Discharge [ ] Dishonorable Discharge

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: