Patient Information/Consent Form

Patient Name: _____ **Male or Female**

Date of Birth: _____ **Age:** _____

Patient School/Employer: _____

Parent/Guardian: _____ **Phone:** _____

Address: _____

Emergency Contact: _____ **Phone:**_____

People Living in Your Home:

Name	Age	Relationship	School/Employer

Describe any major medical/physical problems and allergies: _____

_____

_____

List current medications:

Medication	Start	Dosage	Prescribing MD	Duration

Presenting Problem: _____

_____

_____

Treatment Goals (to be completed with or by therapist): _____

_____

_____

I give my permission for psychological evaluation, treatment, and/or testing of patient above.

I have read and understand the HIPAA Compliance Policy. I can request a copy of the HIPAA Compliance Policy at any time.

_____ _____

Parent/Guardian Signature and Date Service Provider's Signature and Date

daily BEHAVIORAL HEALTH