Edmondson Counseling Services, PC

Patient Information

Date:________________ Therapist:______________________________

First Name:____________________ MI____ Last Name_____________________________________

Address:_______________________________City:________________ State:_____ Zip:__________

		OK to contact:		OK to leave message:	
Home Phone	( )____________________	Yes__	No__	Yes__	No__
Cell Phone	( )____________________	Yes __	No__	Yes__	No__
Work Phone	( )____________________	Yes__	No__	Yes__	No__

E-mail address:_______________________________________

Age:____ Birth Date:_________ Race:____________ Gender M__ F__ Marital: M__ S__ W__ D__

Occupation:_____________________ Employer:____

Employer's Address:____

Spouse:________________ Occupation:______________ Employer:__________________________

How many children?__________ Names and Ages of Children:__________________________________

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Are you planning to use Insurance? Yes__ No__

Are you the Insured? Yes__ No__

If No, Policyholder's Name_______________________________ Policyholder's Birth Date:____________

Name of Emergency Contact:____________________________ Phone:_________________________

How were you referred to our office?____

Primary Care Physician (first and last name): ____