_____

_____

Current Medications_____

_____

Allergies_____
_____

CURRENT Employment Information

Place of employment? _____
How long have you been at this job? _____

Referral Source

How did you hear about my services? (or from whom)?_____
_____

Phone_____

Relationship to referral source_____

FAMILY OF ORIGIN: (please give names, ages, and where they live, and if they are deceased or living)

Mother:

Father:

Siblings:

NOTE: Is there a history of psychiatric/mental illness in your family? Substance Abuse? If so, please explain below (please include if any relative was prescribed a particular medication for this disorder).

Emergency Information

In case of emergency, contact:
Name _____ Relationship_____
Phone_____Work_____
Address_____ City_____
State_____ Zip_____

CURRENT HEALTH INFORMATION:

Physician (Primary Care)_____

Phone_____
Psychiatrist_____ Phone_____

Current Health Problems _____

Stacy N Broun, PhD

Clinical Psychologist

3609 Cedar Springs Rd. Dallas, TX. 75219 214.521.6972
www.drbroun.com

INITIAL INFORMATION

Please Print Clearly **THIS SHEET MUST BE FILLED IN COMPLETELY**

Date_____ Social Security #_____
First Name_____Last Name_____MI_____
Address_____ City_____
State_____ Zip_____

(Please circle the phone number that you prefer I use to contact you)
Telephone (Home)_____ (Work)_____
E-Mail Address_____
Birth date___/____/____ Age_____

MARITAL STATUS: **Married** **Divorced** **Partnered** **Widowed** **Single**

Name of Spouse_____
Phone_____
Address_____ City_____
State_____ Zip_____

CHILDREN: YES NO

If Yes: Names and Ages :
1.

2.

3.