

CLIENT INFORMATION (ADULT)

Full Legal Name: _____ **Today's Date:** _____

If necessary, I give Dr. McCaskill permission to call me at the following numbers:

Home Phone# _____	OK to leave a message:	Yes	No
Work Phone # _____	OK to leave a message:	Yes	No
Cell Phone # _____	OK to leave a message:	Yes	No
Other # _____	OK to leave a message:	Yes	No

Age ____ **Date of Birth** ____ / ____ / ____

Address _____ **City** _____ **Zip** _____

Occupation _____
SS# _____

Place of Employment _____

Type of Employment ____ **Full time** ____ **Part time**

Highest Grade Completed _____ **Sex** ____ **M** ____ **F**

Relationship Status (Please circle one)
Never Married **Married** **Partnered** **Separated** **Divorced** **Widowed**

Are you involved in any legal cases at the present time? **Yes** **No**
If yes, please explain: _____

List Family Members (Parents/Siblings or Partner/Spouse/Children)
Name **Relationship** **Age** **Occupation (or grade)**

Emergency Contact Person: _____ **Relationship to you:** _____
Work or Daytime Phone _____ **Home Phone** _____

Primary Physician _____ **Phone #** _____

Please list any current medications (including birth control pills) and /or physical health problems:

Significant past health problems: _____
Who referred you to my office? _____

***I think it would be helpful for Dr. McCaskill to contact the following professionals, who also participate (or have participated) in my care (i.e., physicians, therapists, etc.)**

Name: _____

Profession: _____

Address: _____ City: _____ Zip: _____

Phone #: _____

Name: _____

Profession: _____

Address: _____ City: _____ Zip: _____

Phone #: _____

Name: _____

Profession: _____

Address: _____ City: _____ Zip: _____

Phone #: _____

**Please see Dr. McCaskill to sign a written request so that she may contact the professionals cited above.*