Michael L. Hendricks, Ph.D., ABPP, PLLC
(PLEASE PRINT)

NAME: _____ AGE: _____
LAST FIRST MIDDLE

NAME YOU WISH TO BE CALLED BY: _____ DATE OF BIRTH: _____

ADDRESS: _____ TELEPHONE
HOME

ZIP: _____
OFFICE

E-MAIL ADDRESS: _____

REFERRED BY: _____

GENDER: _____ RELATIONSHIP STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Significant Other

OCCUPATION: _____ INSURANCE CO: _____

EMPLOYED BY: _____ SUBSCRIBER NO: _____

ADDRESS: _____ GROUP NO.: _____

SIGNATURE: _____ TODAY'S DATE
PATIENT OR LEGALLY RESPONSIBLE PARTY

FAMILY INFORMATION:	AGE	DECEASED DATE	OCCUPATION	EDUCATION	STATE OF HEALTH
FATHER					
MOTHER					
STEP-FATHER					
STEP-MOTHER					
BROTHERS/SISTERS (Circle Sex)					
M F					
M F					
M F					
M F					
M F					
SPOUSE/PARTNER M F					
SONS/DAUGHTERS M F					
M F					
M F					
M F					
M F					

EDUCATION: HIGHEST DEGREE: _____

WHERE OBTAINED: _____

HEALTH:

a. How would you describe your general health?

b. What medication(s), if any, are you taking presently? For what condition(s)?

c. When was your last physical examination?

d. Name and phone number of your physician:

e. Please list any noteworthy physical problems:

(OVER)

BRIEF (1-2 Sentences) DESCRIPTION OF PROBLEM FOR WHICH YOU ARE SEEKING HELP:

GOALS FOR THERAPY:

PREVIOUS PSYCHOTHERAPY/COUNSELING :

a. Therapist's Name and Address:

Circle: Individual Group Couple/Family

Duration of Treatment: From To Session Frequency/Week:

b. Therapist's Name and Address:

Circle: Individual Group Couple/Family

Duration of Treatment: From To Session Frequency/Week:

History of Hospitalizations:

a. Hospital Dates:

Reason:

b. Hospital: Dates:

Reason:

SPECIAL INTERESTS/HOBBIES: (Please Describe)