CHAPEL HILL PEDIATRIC PSYCHOLOGY, P.A.
205 SAGE ROAD, SUITE 201
CHAPEL HILL, NC 27514
(919) 942-4166

ADULT CLIENT QUESTIONNAIRE

Date _____

Full Name _____ Gender_____ Birthdate_____

Address _____
Street City State County Zip

Home Phone _____ Can we leave a message w/ a person? Y/N voicemail? Y/N

Cell Phone _____ Can we leave a message w/ a person? Y/N voicemail? Y/N

Work Phone_____ Can we leave a message w/ a person? Y/N voicemail? Y/N

E-mail address _____

Who referred you? _____
name address

Primary Physician _____ : _____

Insurance Company_____ Subscriber ID# _____

Subscriber Name _____ Subscriber Date of Birth _____

Can we contact parent(s) or responsible party as needed? [ ]Yes [ ]No

Will you be financially responsible for these services? [ ]Yes [ ]No; If "No," please complete the box below

Responsible Party Information

Name _____ Relationship to Client_____

Address_____
Street City State County Zip

Home Phone_____ Cell Phone_____ Work Phone_____

Marital Status: [ ]Single, never married [ ]Married [ ]Separated [ ]Divorced [ ]Widowed [ ]Remarried

Occupation _____ Educational Level _____ # of Dependents _____

Partner's Name _____ Birthdate _____

Occupation _____ Educational Level_____ # of Dependents _____

List all other persons living in the home:

Name	Age	Relationship to Client	Present Health

FAMILY AND PERSONAL HEALTH HISTORY

Note: Please complete all information on this report. All information is treated in confidence and will not be released without your permission.

FAMILY RECORD Check (✓) condition and relationship of any blood relative who has or has had any of the conditions listed below:	NONE	CLIENT	BIO-FATHER	BIO-MOTHER	GRANDFATHER	GRANDMOTHER	BROTHER	SISTER	SON	DAUGHTER	OTHER	INDICATE OTHER RELATIVE
Alcoholism/Substance Abuse												
Allergies												
Birth Defects												
Cancer												
Colitis												
Depression												
Anxiety												
Heart Attack												
High Blood Pressure												
Kidney Disease												
Liver Disease												
Migraines												
Mental Illness												
Seizure Disorder												
Mental Retardation/Intellectual Disability												
Autism/Asperger's												
Developmental Disability												
Learning Disorder												
Attention Problems												
Suicide/Suicide Attempt												
Thyroid Problems												
Eating Disorder												

Family Member	Living?	Age	Current Health: Good	Fair	Poor	If Deceased, Cause of Death
Parent 1						
Parent 2						
Brothers						
Sisters						

Last Physical Exam Date_____

Results _____

_____

Current medication(s)_____

_____

If you share custody of your children, please describe the arrangement; including visitation, schedule, and custody status

Have you had any prior therapy or parent consultations? [ ]Yes [ ]No; If "Yes," please elaborate

Please provide a brief description of how we can help you