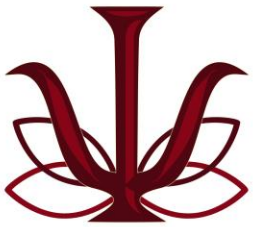

Dr. Michelle Channing, P.A.

NAME:_____MALE/FEMALE:_____DATE:_____
REFERRAL SOURCE: _____

DATE OF BIRTH/PLACE: _____ AGE: _____

SOCIAL SECURITY #:_____ DRIVER'S LICENSE #:_____

STATUS: Single ( ) Married ( ) Separated ( ) Divorced ( ) Widow/er ( ) Other ( )

IF CHILD/ADOLESCENT, PARENT/GUARDIAN'S NAME(S): _____

ADDRESS: _____ CITY: _____ ZIP:_____

PRIMARY LANGUAGE: _____ SECONDARY LANGUAGE: _____

FOR ROUTINE MESSAGES: Phone #_____ ( ) Cell ( ) Home ( ) Work

Alternative Phone #_____ ( ) Cell ( ) Home ( ) Work

FOR CONFIDENTIAL MESSAGES: Phone #_____ ( ) Cell ( ) Home ( ) Work

Alternative Phone #_____ ( ) Cell ( ) Home ( ) Work

PERSON & PHONE # TO CALL IN EMERGENCY: _____

I consent and authorize my mental health practitioner and/or their staff to communicate with the contact person above regarding all confidential matters in a situation deemed as an emergency.

Patient/Guardian's Signature: _____ Date: _____

E-MAIL: _____

Do you e-mail regularly? ( ) Yes ( ) No Okay to e-mail appointment/billing info? ( ) Yes ( ) No

Okay to e-mail confidential info? ( ) Yes ( ) No Okay to e-mail newsletters? ( ) Yes ( ) No

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____

EMPLOYER: _____ OCCUPATION: _____

PURPOSE OF VISIT: _____

HISTORY OF PRESENTING PROBLEM: _____

ESTIMATE THE SEVERITY OF THE ABOVE PROBLEM: ( ) Mild ( ) Moderate ( ) Severe

LEGAL HISTORY: ( ) Current ( ) Past _____

CURRENT MEDICATIONS & DOSAGES:_____

_____

IF PATIENT IS A CHILD:

Name of school _____ Grade _____ Teacher(s) _____

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