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Adult Client Information Form

Today's date: _____

Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Date of birth: _____ Age: _____
Nicknames or aliases: _____ Social Security #: _____
Home street address: _____ Apt.: _____
City: _____ State: _____ Zip: _____
Home/evening phone: _____ E-mail: _____
Calls or e-mail will be discreet, but please indicate any restrictions: _____

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____
Address: _____

May I have your permission to thank this person for the referral? Yes No

How did this person explain how I might be of help to you? _____

C. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____
Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

D. Your current employer

Employer: _____ Address: _____

Work phone: _____ Calls will be discreet, but please indicate any restrictions: _____

E. Your education and training

Date From:	Date To:	Schools	Special classes?	Adjustment to school	Did you graduate?

F. Employment and military experiences

Date From:	Date To:	Name of military or employers	Job title or duties	Reason for leaving

G. Family-of-origin history

Relative	Name	Current age (or age at death)	Illnesses (or cause of death, if deceased)	Education	Occupation
Father					
Mother					
Stepparent(s)					
Grandparent(s)					
Aunt(s)/Uncle(s)					
Brother(s)					
Sister(s)					

H. Significant non-marital relationships

Relative	Name of other person	Person's age when started	Your age when started	Your age when ended	Reasons for ending
First					
Second					
Third					
Current					

I. Marital/relationship history

Relative	Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed?	Is spouse remarried?
First					
Second					
Third					

J. Children (Indicate which are from a previous marriage or relationship with the letter P in the last column)

Name	Current Age	Sex	School	Grade	Adjustment problems?	P?

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.