



**Kathleen B. Corcoran, Ph.D., Inc.**

Please complete the following information and print clearly.

**CLIENT INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

How would you like to be addressed? \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell/Alternate Home Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Days & Time Generally at Home: Days \_\_\_\_\_ Times \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Work Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_ Days & Time at Work: Days \_\_\_\_\_ Times \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Sex: Male Female Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_

Relationship Status:

Single \_\_\_\_ Married \_\_\_\_ In a Committed Relationship \_\_\_\_ Widowed \_\_\_\_ Divorced \_\_\_\_ Separated \_\_\_\_

**RESPONSIBLE PARTY FOR PAYING THE FEE** Same as above \_\_\_\_\_

*If responsible party is not the same as above, please complete this section for the responsible party.*

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

Relationship to the client: Partner Parent Other \_\_\_\_\_ Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_

**REFERRED BY**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ May we thank the referral? Yes No Please Initial \_\_\_\_\_

## INSURANCE INFORMATION

Insurance Company Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address to Submit Claims \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Contact Person at Insurance Company \_\_\_\_\_ Group No \_\_\_\_\_

Subscriber's Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Subscriber's Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

Subscriber's ID \_\_\_\_\_ D.O.B. \_\_\_\_\_ Soc. Security # \_\_\_\_\_

## ADDITIONAL CLIENT INFORMATION

Please Fill in the Blanks for all Persons Living with the Client

NAME	AGE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

When Was Your Last Medical Checkup? \_\_\_\_\_ Who is Your Primary Care Doctor? \_\_\_\_\_

Please Describe Your Caffeine Intake \_\_\_\_\_ If You Smoke, How Much? \_\_\_\_\_

If You Are Taking Any Medications, Herbs Or Supplements, Please Fill Out The Following Chart:

MEDICATIONS HERBS/SUPPLEMENTS	DOSAGE (Amt. & Time)	STARTED WHEN?	TAKING FOR WHAT PURPOSE	PRESCRIBING DOCTOR
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

## IN CASE OF AN EMERGENCY, WHO SHOULD BE CONTACTED?

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_