Lansing Psychological Associates, P.C.
234 Michigan Avenue
East Lansing, MI 48823
(517) 337-6545 FAX (517) 337-3010

ADULT PERSONAL DATA SHEET

Please complete the following. All material is confidential and will not be released except on your written request.

Name: ____ Date: ___________________

Address: ____

Street Apt. No.

____

City State ZIP

Home No.: ___________________ Work No.: __________________ Cell No.: _________________

If we need to contact you, please indicate number we may use: ____ Home ____ Work ____ Cell

Social Security Number: ________________________ Date of Birth: _____________________

Age: _______ Sex: _______ Place of Birth: _______________________________________

Occupation: ______________________ Place of Employment: _______________________

Marital Status: ________________ If married, spouse's name: __________________________

If married more than once, list dates and length of time married and whether marriage was terminated by divorce, annulment, or death:

____

Names and ages of any children: ____

____

How far did you go in school? ______________ Military Service? ___________________

Who referred you here? ____

Have you previously been seen at this clinic? _______

If yes, approximately how long ago? __________________________

Please state the problems that you are experiencing: ___________________________________

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____

Please list all medications you are currently taking:

Medication	Dosage and How Often	What Reason	How Long
____________________	____________________	_____________	__________
____________________	____________________	_____________	__________
____________________	____________________	_____________	__________
____________________	____________________	_____________	__________
____________________	____________________	_____________	__________
____________________	____________________	_____________	__________
____________________	____________________	_____________	__________

Name and address of family doctor: ____

Date of last physical exam: ______________ Findings within normal limits? Yes ___ No ___

If no, specify problems/diagnoses: ____

____

Please list any disabilities which you might have: ____

____

Please list any benefits (treatment and/or monetary) that you currently receive because of your disabilities:

____

What allergies or sensitivities do you have? ____

Do you have insurance that will pay for psychological services? _______

Name of insurance company: ____

Policyholder's name: ______________________________ Group Policy No. __________________

Your relationship to policyholder: _______________________ Policyholder's DOB: __________

Contract number or policyholder social security number: _________________________________

Policyholder's Employer: ____

Please list any other health benefits or secondary insurances you may have: __________________

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In case of an emergency, please give name and address of a person you would like notified:

Name: _______________________________________ Relationship: ____________________

Address: _____________________________________ Phone No.: _______________________

Street Apt. No.

____

City State ZIP