Neurodiversity, LLC

ADULT PERSONAL DATA SHEET

Please complete the following. All material is confidential and will not be released except with 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____

Soc. Sec. #: _____ Date of Birth: _____ Birth Place: _____

Age: _____ Gender: _____ Ethnicity Origin (or race):_____

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, approx. how long ago?_____

Have you had any psychiatric hospitalizations in the past? If yes, list facility and date(s) _____

_____

Please state the problems that you are experiencing: _____

_____

_____

_____

_____

_____

Please list all medications you are currently taking:

Medication	Dosage and How Often	What Reason	How Long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name and phone # 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: _____

_____

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

Name: _____ Relationship: _____ Phone No.: _____

Address:

_____
Street Apt. No. City State ZIP

Do you have an advanced directive? Yes ____ No ____

Comment: _____