Robin L. Billings, PhD, PLLC
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CLIENT INFORMATION (ADULT)

Full Legal Name:______________________________ **Today's Date:** _________

If necessary, I give Dr. Billings permission to call me at the following numbers:

Home Phone# ______________________ **OK to leave a message: Yes No**

Work Phone #______________________ **OK to leave a message: Yes No**

Cell Phone #________________________ **OK to leave a message: Yes No**

Email: ____

Age _____ **Date of Birth**____/_____/____

Address____

City_____________________________ **Zip**____________________

Occupation____

SS#___________________________________

Place of Employment____

Type of Employment ____**Full time** ____**Part time**

Highest Grade Completed ___________ **Sex** _____**M** _____**F**

Relationship Status (Please circle one)

Never Married Married Partnered Separated Divorced Widowed

Are you involved in any legal cases at the present time? Yes No

If yes, please explain: ____

List Family Members (Parents/Siblings or Partner/Spouse/Children)

Name	Relationship	Age	Occupation (or grade)

Emergency Contact Person: ___________________ **Relationship to you:** _______________

Work or Daytime Phone _________________ **Home Phone** ___________________________

Primary Physician __________________________________**Phone #**____________________

Please list any current medications (including birth control pills) and /or physical health problems:

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____

Significant past health problems: ____

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Who referred you to my office? ____

Please use the remaining space for any additional information that would be helpful for me to know about you.