Alicia Tisdale, Ph.D.
Licensed Psychologist

CLIENT INFORMATION

Gathering information about you in this matter will facilitate the initial intake process and provide valuable data. Please take a moment to complete this form. As with all your records, this will be confidential. Thank you.

Date:_____

General Information

Name_____Age_____Birth Date_____
Address_____City_____Zip_____
Phone (Home)_____(Work)_____ (Cell)_____
Employed By_____How Long_____
School_____Present Grade_____
How Referred_____ Method of Payment_____

Current Household Composition (include Yourself, Spouse, Children)

Name Relationship Age Education Soc.Sec.# DOB Occupation

_____
_____
_____
_____
_____

Religious Affiliation_____

Are you being seen by any other professional person at this time? (Physician, Clergy, Therapist)
Yes_____No_____ If yes, please explain:

Responsible Party :Complete this section if the patient is not responsible for the bill.
Name_____ Birth Date_____
Relationship to Patient_____ Address_____
Home Phone_____Work Phone_____
City_____State____Zip___

I, as the responsible party understand that I will be responsible for all charges.
In the case of cancellation, it is required that a 24 hour notice be given to Dr.Tisdale or you may be responsible for payment of that visit and this cost is not covered under insurance.

_____
Signature of Responsible Party