

CLINICAL PATIENT INFORMATION
CORNERSTONE PSYCHOLOGICAL SERVICES

PATIENT NAME: _____ PHONE _____
DATE OF BIRTH: _____ GENDER: _____
(IF MINOR) PARENT/GUARDIAN: _____
EMERGENCY CONTACT: _____ PHONE# _____
RELATIONSHIP: _____

PEOPLE LIVING IN YOUR HOUSE:

NAME	AGE	RELATIONSHIP	SCHOOL / EMPLOYER
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DESCRIBE ANY MAJOR MEDICAL / PHYSICAL PROBLEMS: _____

LIST CURRENT MEDICATIONS:

MEDICATION	START	DAILY DOSAGE	PRESCRIBING MD	DURATION
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PRESENTING PROBLEM: _____

I give my permission for psychological evaluation and or treatment and testing (if indicated) of

(Patient, if a minor)

Patient or Guardian Signature / Date

Therapist Signature / Date