. **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: ____________________________
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LIST CURRENT MEDICATIONS:

MEDICATION	START	DAILY DOSAGE	PRESCRIBING MD	DURATION

PRESENTING PROBLEM: ____
____
____
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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