KENNETH A. DE LUCA, Ph.D. & Associates, Inc.

ADULT REQUEST FOR SERVICES

****The following is vital information in helping us to help you. Thank you!****

DATE: _____

NAME: _____
(LAST) (FIRST) (MI)

ADDRESS: _____
(STREET) (CITY) (ZIPCODE)

PHONE: _____ S.S.NO: _____

BIRTHDATE: _____ AGE: _____ SEX: ____ MARITAL STATUS: _____

EDUCATION: _____ OCCUPATION: _____

EMPLOYER: _____ PHONE: _____

BEST NUMBER TO REACH YOU AT 1. _____ 2. _____ 3. _____

Please briefly describe the reason for your visit: _____
_____
_____
_____

List all immediate family and significant relationships:

Name	Relationship	Age	Health Issues (specify)

Marital and Relationship History:

☐ Never married ☐ In relationship now How long: _____

☐ Married Date: _____ ☐ Separated Date: _____

☐ Divorced Date: _____ ☐ 2nd Marriage Date: _____

☐ 2nd Divorce Date: _____ ☐ Widowed Date: _____

ADDITIONAL INFO: _____

SPOUSE'S NAME: _____ S.S.#: _____ AGE: _____ DOB: _____

SPOUSE'S OCCUPATION/EMPLOYER: _____

Please list any stressors that you have experienced recently (i.e. job change or loss, family illness or injury, accidents, death, moves, violence, crime victimization, etc.): _____
_____
_____

Please describe any PAST or PENDING legal matters including visitation/custody proceedings:

_____

_____

Please list any mental health services or chemical dependency; including counseling, you or a family member have previously received:

Name	Provider/Agency	Dates	Reason	Outpatient and/or Inpatient

Please list any major, chronic, significant illnesses or conditions you have had including injuries due to accident.

_____

_____

_____

_____

CURRENT MEDICATIONS

Name	Dosage	Purpose	Prescribing Doctor	Side Effects?

- **ALLERGIES TO MEDICATIONS:** _____
- **EMERGENCY CONTACT:** _____
  (Name) (phone) (relationship)
- **REFERRAL SOURCE or why, or how, did you select us?**
  _____
- I understand that my records are protected by laws governing confidentiality and cannot be disclosed without my written consent. I understand that I can revoke my consent at any time except when disclosure has already occurred. This consent will automatically expire twelve months from the date signed.
- Please check one: ___Please release any applicable information to my primary care /referring physician.
  ___Do not release any information to my physician. ___I do not have a primary care physician.
- **Primary Care Physician's Name, Address & Telephone Number:**
  _____
  _____

I agree and consent to participate in mental health services offered and provided by Kenneth A. De Luca, Ph.D. & Associates, Inc. I have reviewed a copy of the Ohio Notice Form: Notice of Psychologist/Counselor and Social Workers' Policies and Practices to Protect the Privacy of Your Health Information.

Client Signature: _____ Date: _____
(Legal Guardian / Power of Attorney Signature)

Clinician Signature: _____ Date: _____