**Bonnie L. Atkinson, Ph.D., L.L.C.**
**444 N. Cedar Street**
**Florence, AL 35630**

Diagnosis:

__________ __________ ________________________________ MI, MO, S
__________ __________ ________________________________ MI, MO, S
__________ __________ ________________________________ MI, MO, S
__________ __________ ________________________________ MI, MO, S
__________ __________ ________________________________ MI, MO, S

Case: _____________

Date Of Service: ________________________ Prognosis: ________________________________________

## INTAKE INFORMATION FOR ADULTS

***(Please print clearly)***

**PERSONAL INFORMATION:**

Patient Name: ______________________________________________ Age: _____ Date of Birth: ____/____/____

Social Security Number: ______-______-______

Address: ____________________________________ City:______ ______________ State: _____ Zip: _________

Phone - Cell: (____)___________________ Home: (____)__________ ________Work: (____)__________________

Email Address: _________________________________ Education Level: ________________________________

Primary Care Physician: ______________________________________________________________________

Medication and Dosage: ______________________________________________________________________

Health Problems:____________________________________________________________________________

Marital Status: □ Married (how long)_________ □ Divorced □ Single □ Widowed

Names/Ages of All Children: ___________________________________________________________________

Employer of Patient: __________________________________ How Long: ________ Position:_________________

Address: ____________________________________________________ Phone: (____)______________________

Name of Spouse: ___________________________ __________________Age: ______ Date of Birth: ____/____/____

Address:___________________________________ City:_________ _______________ State: _____ Zip: ________

Employer: ____________________________ How Long: _________ Position: _____________

Have you Ever Received Counseling Before: □ Yes □ No

If Yes, When and By Whom: _____________________________________________________________________

Church Affiliation: ____________________________________________________________________________

Known Allergies: _____________________________________________________________________________

**RESPONSIBLE PARTY INFORMATION:**

Responsible Party: ________________________________________________________ Date of Birth: ____/____/____

Address: _______________________________________ City:_______ _____________ State: _____ Zip: ___________

Phone – Cell: (____)____________ ______ Home: (____)_________________ Work:(___)________________________

Insurance Co. Name/Address: ___________________________________________________________________

SSN# _________________________ Contract #______ __________________ Group # __________________________

Employer of Insured: __________________________________________________________________________

**EMERGENCY INFORMATION:**

Contact Person (in case of emergency other than spouse): ___________________________________________

Relationship: _______________________________________ Phone: (____)___________________________

Address: _____________________________________ City:_______ _______________ State: _____ Zip: __________

Referred By: ___________________________________

Patient Signature:__________________________________________________Date:____________________________