

Heidi S. Lack, Ph.D., A.T.R.-BC

Licensed Psychologist

Health Service Provider

Registered, Board certified Art Therapist

BIOGRAPHICAL INFORMATION

NAME: _____ **M/F** **SS#** _____ **DATE:** _____ **D.O.B.:** _____ **Age:** _____

TELEPHONE: **H :** _____ **W:** _____ **C:** _____ **Fax:** _____

ADDRESS: _____

Occupation/Position: _____ **E-Mail:** _____

Referred By _____ **or How you heard of this practice:** _____

Person To Call In Emergency: _____ **Contact Number:** _____

Relationship _____

Presenting Problem-Reason for seeking evaluation/treatment:

Marital/Partnership Status: _____ **Former/Present Marriage(s)/Partnership (Years):** _____

Spouse/Partner's Name: _____ **Age:** ____ **Occupation** _____

Children/Step (Names/Ages) :

Siblings (Names/Ages): _____

Parents/Step-Parent(S) (Ages or Age at and Year of Death):

Medical Doctor(s): _____ **Phone:** _____

Date and result of Last Exam: _____

Past/Present Medical Care (Specify: Major Problems, Hospitalizations, Current Medication with dosage):

Past/Present Counseling/Psychotherapy/Hospitalization:

Past/Present Addiction Use/Abuse (AA/NA/OA Etc.): Drug/Alcohol/Food/Computer

Family History of ADD, Mental Illness, Substance abuse:

Feel free to use the space on the back to provide further detail