Dr. Amelia Hardwick
Clinical Psychologist
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Client Information

Name of Patient_____ **Date**_____
Name of Parent/Guardian (If minor)_____
Address_____**ZIP**_____
Home Phone_____**Work Phone**_____**Cell**_____
E-mail_____
Date of Birth _____**Place of Birth**_____**Ethnicity**_____
Marital Status ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed** ☐ **Domestic Partnership**

Education (years)_____**Last/Current School**_____**Degree**_____
Occupation_____**Name of Employer**_____
Address/Phone_____
Spiritual/ReligiousOrientation_____
I attend religious services: ☐ **Never** ☐ **Special Occasions/Rarely** ☐ **Monthly** ☐ **Weekly**
Any current health/medical conditions _____
Name of Spouse/Partner_____
Address_____**ZIP**_____
HomePhone_____**WorkPhone**_____**Cell**_____
Date Of Birth_____**Ethnicity**_____**Occupation**_____
Employer,Address/Phone_____
NAMES OF CHILDREN AGE DOB
1. _____**4.**_____
2. _____**5.**_____
3. _____**6.**_____
Emergency Contact, Address/Phone_____
Relationship_____
Who Referred you to this office?_____
May I contact this person to thank them for the referral? Y/N_____**Signature**

Insurance Carrier: _____ **ID#:** _____ **Grp#:** _____
Date of Birth: _____ **Effective Date:** _____ **Type: HMO/PPO**
I authorize Dr. Hardwick to release necessary information with my insurance Company to obtain payment and authorization for treatment.

X _____ **Date:** _____

Print Name: _____