

Nyla McCulloch, LICSW
One West Water Street
Wakefield, MA. 01880

ADULT CLIENT INFORMATION FORM

NAME: _____ PHONE: Cell: _____

DOB: _____ Home: _____

ADDRESS: _____ Work: _____

CITY: _____ ZIP: _____ Okay to leave message?: _____

PREFERRED PRONOUNS: _____ EMAIL: _____

EMERGENCY CONTACT: _____

Relationship: _____

Phone: _____

OCCUPATION:

Self: _____ Spouse/Partner/SO: _____

Employer: _____ Employer: _____

HEALTH:

Approximate Date of Last Physical Exam: _____ PCP: _____

Phone: _____

General Health:

____ Excellent ____ Good ____ Fair ____ Poor

Significant Medical Issues: _____

Medication/Dosage	Condition	Prescribed by	Phone
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Previous Therapy Experience:

With Whom	Where	When	Regarding
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Significant Psychiatric/Hospitalization History:

Alcohol/Substance Use: _____

Please describe briefly the circumstances which led you to seek this consultation:

Referred By: _____