MICHAEL R. LaVALLE, Ph.D.

GENERAL INFORMATION

Date: _____

Name: _____ Age: _____

Address: _____

_____

Occupation: _____ Employer: _____

Highest Grade/Degree: _____

Birthdate: _____

E-mail: _____

Phones: (cell) _____ Voicemail msg okay? Yes No

(home) _____ Voicemail msg okay? Yes No

(work) _____ Voicemail msg okay? Yes No

Marital status (circle): never married married partnered separated divorced widowed

FAMILY:

Spouse Name: _____ Age: _____

Occupation: _____ Employer: _____

Highest Grade/Degree: _____

Children Names and Ages: _____

_____

Others Living in Home: _____

Mother's Name: _____ Age: _____

Occupation: _____

Highest Grade/Degree: _____

Father's Name: _____ Age: _____

Occupation: _____

Highest Grade/Degree: _____

OTHER HEALTH/SERVICE PROVIDERS (e.g., Primary Care Physician, Psychiatrist, etc.):

Name: _____ Provider Role: _____

Phone: _____

Name: _____ Provider Role: _____

Phone: _____

EMERGENCY CONTACT:

Name: _____ Relationship to Patient: _____

Phone: _____

Referred by: _____

Consent to acknowledge the referral? (circle one) Yes No