Kari Lenox, Ph.D.

Kari@karilenox.com
Phone: (919) 237-2250
Fax: (919) 251-9660

COLLEGE AGE PATIENT INFORMATION

DATE: **ACCOUNT NO.:** **DX:**		
COLLEGE AGE PATIENT INFORMATION		
Last Name:	First Name:	Nickname:
Birthdate: / /	Age:	Gender:
Marital Status: □ Single □ Separated □ Divorced □ Married		Languages spoken at home:
Street Address: City: State: Zip Code:		
Home Phone:	Student's cell phone:	Best number to leave messages:
Have you or a family member been seen by Dr. Lenox before? Y or N		
REFERRAL INFORMATION		
Referred by: _____	How did you learn about this practice: □ Doctor □ Lawyer □ Friend □ School □ Co-worker □ Internet search □ Presentation/Talk □ Marketing □ Other	
SCHOOL INFORMATION		
Current School:		Major:
Level:		Minor:

PARENT INFORMATION		
	MOTHER	**FATHER**
Name		
Age		
Highest Education Level		
Occupation		
Employer		
Cell Phone		
Work Phone		
Home Phone (if different from patient)		
Email Address		
Address (if different from patient)		
	STEPMOTHER	**STEPFATHER**
Name		
Age		
Highest Education Level		
Occupation		
Employer		
Cell Phone		
Work Phone		
Home Phone (if different from patient)		
Email Address		
Address (if different from patient)		

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SIBLINGS		
Names: 1-	Gender : Age:	□ Full Sibling □ Half □ Step □ Adopted
2-	Gender : Age:	□ Full Sibling □ Half □ Step □ Adopted
3-	Gender : Age:	□ Full Sibling □ Half □ Step □ Adopted
4-	Gender : Age:	□ Full Sibling □ Half □ Step □ Adopted

MEDICAL INFORMATION			
Doctor:	Phone:	Fax:	
Street Address:	City:	State:	Zip Code:
Medical Problems (list):			
Allergies:			
Hospitalizations/Surgeries:			
Medication Name:	Dosage:	X per day:	Reason:
Medication Name:	Dosage:	X per day:	Reason:
Medication Name:	Dosage:	X per day:	Reason:

MENTAL HEALTH HISTORY

Mental Health Diagnoses:

Previous Professionals Seen: Name(s): Date(s):

Previous Evaluations: □ Psychological □ Educational □ Speech and Language □ Occupational Therapy
□ Neuropsychological □ Emotional □ Behavioral

FAMILY STRESSORS

□ Abuse □ Deaths □ Job □ Relocation □ Stepchildren □ Trauma
□ Births □ Divorce □ Marriage □ School □ Substance Use □ Other(s):
□ Bullying □ Finances □ Medical □ Separation □ Substance Abuse

FAMILY STRENGTHS

Please Describe:

REASON FOR SEEKING HELP AT THIS TIME:

Please Describe:

FINANCIAL MATTERS

Who is responsible for payment of services?

If the responsible party is someone other than yourself, it is often easiest to ask this person to sign an authorization form to allow their credit card be used each session. Please discuss the Business Policy and Agreement and Authorization for credit card use with this person and return these forms along with the Financial Responsibility form. ***I understand that I give my permission to discuss financial matters with my parents if they are paying for treatment.***

Signature: Date: