

Lansing Psychological Associates  
234 Michigan Avenue  
East Lansing, MI 48823  
(517) 337-6545 FAX (517) 337-3010

**ADULT PERSONAL DATA SHEET**

Please complete the following. All material is confidential and will not be released except with your written request.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt. No.

City State ZIP

Home No.: \_\_\_\_\_ Work No.: \_\_\_\_\_ Cell No.: \_\_\_\_\_

If we need to contact you, please indicate number we may use: Home \_\_\_\_ Work \_\_\_\_ Cell \_\_\_\_

Soc. Sec. #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Birth Place: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Ethnicity Origin (or race): \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Marital Status: \_\_\_\_\_ If married, spouse's name: \_\_\_\_\_

If married more than once, list dates and length of time married and whether marriage was terminated by divorce, annulment, or death:

\_\_\_\_\_

Names and ages of any children: \_\_\_\_\_

\_\_\_\_\_

How far did you go in school? \_\_\_\_\_ Military Service? \_\_\_\_\_

Who referred you here? \_\_\_\_\_

Have you previously been seen at this clinic? \_\_\_\_\_ If yes, approx. how long ago? \_\_\_\_\_

Have you had any psychiatric hospitalizations in the past? If yes, list facility and date(s) \_\_\_\_\_

\_\_\_\_\_

Please state the problems that you are experiencing: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Please list all medications you are currently taking:

Medication	Dosage and How Often	What Reason	How Long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name and phone # of family doctor: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_ Findings within normal limits? Yes \_\_\_ No \_\_\_

If no, specify problems/diagnoses: \_\_\_\_\_

Please list any disabilities which you might have: \_\_\_\_\_

Please list any benefits (treatment and/or monetary) that you currently receive because of your disabilities:

What allergies or sensitivities do you have? \_\_\_\_\_

Do you have insurance that will pay for psychological services? \_\_\_\_\_

Name of insurance company: \_\_\_\_\_

Policyholder's name: \_\_\_\_\_ Group Policy No. \_\_\_\_\_

Your relationship to policyholder: \_\_\_\_\_ Policyholder's DOB: \_\_\_\_\_

Contract number or policyholder social security number: \_\_\_\_\_

Policyholder's Employer: \_\_\_\_\_

Please list any other health benefits or secondary insurances you may have: \_\_\_\_\_

In case of an emergency, please give name and address of a person you would like notified:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Address:

\_\_\_\_\_ Street Apt. No. City State ZIP

Do you have an advanced directive? Yes \_\_\_ No \_\_\_

Comment: \_\_\_\_\_