REID WHITESIDE, Ph.D., P.C.

NEW PATIENT INFORMATION

PATIENT's NAME: ___________________ _______________ _________________________________ _______________________
First Middle Last Name prefer to be called by

Today's date: ______________ _____ ______________ Birth date: _____________ _____ _________ ______
Month Day Year Month Day Year Age

Current marital status: ___________________________ Spouse's or partner's name: ________________________________

Check all that apply:
__ Psychological testing, diagnostic
__ Educational, LD, or Gifted testing
__ Evaluation, other: ___________
__ Psychotherapy, individual
__ Psychotherapy, family/parenting
__ Psychotherapy, couple's
__ Psychotherapy, child or teen
__ Employment, career
__ Other:

__ Employed full time __ Employed part-time __ Student, full-time __ Student, part-time __ Unemployed, retired, or other

Referred by: ______________________ Your Physician's name: _______________________ School contact: ______________________

Other health care provider (psychiatrist, psychotherapist, ADHD coach, etc.): ____

PHONE - Home: ___ _________________ Work: ___ ________________ Cell:___ _______________ E-mail: (Complete separate form)
(Place checkmark by preferred number if it is okay to call and leave a discreet message, e.g., asking you to return the phone call)

Patient's Residence Street Address: ______________________________________ City: ________________ State: N.C. Zip + 4: _______

Who else can attend your sessions or take messages, if any, and their relation? ____

Do you have any disabilities under ADA now? ___ Y ___ N Are you involved in or do you anticipate ANY legal litigation? __ Y ___ N

List any medications or medical conditions affecting psychological functioning: ____

Who should be contacted in a medical or psychiatric emergency? ____

SECTION B (Complete only for **minor** patients)

Father: ____
Father's address: ___ Same as patient's; if not, please list below:
____

Mother: ____
Mother's address: ___ Same as patient's; if not, please list below:
____

Dad's phone: H: ___________ W: _____________ C: ___________ Mom's phone: H: ____________ W: ____________ C: _____________

Stepfather: ________________________Phone: _______________ Stepmother: _______________________Phone: ___________________

If patient is a child of separate, divorced, or unmarried parents, please explain the custody arrangement and identify primary residence.

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____

Who is responsible for authorization and payment of costs of medical and psychological services? _____________________________

School and grade: _________________________ _____ School contact person (optional): _________________________

Child's psychiatrist or other provider: __________________ Pediatrician: ____

List any special educational classifications, eligibility, accommodations, or interventions received or eligible for:

Siblings' names and ages:

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