

David W. McMillan, Ph.D.
Confidential Information - Adult

(Please Print)

Name _____ SS# _____ Date _____
 First Middle or maiden last

Age _____ Date of Birth _____ Sex: Male Female Education _____

Home Address _____
 street city state zip

Home Phone _____ Work Phone _____

Occupation _____ Employer _____

Work Address _____
 street city state zip

Marital Status _____ Date of present marriage _____ Date of previous marriages _____

Spouse's name _____ Age _____ Education _____

Spouse's occupation _____ Employer _____

Parents, Siblings, and Children

<u>Name</u>	<u>Relationship</u>	<u>Age</u>	<u>Occupation/Grade</u>	<u>Residence</u>
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Medical Information

Do you have any medical problems? Please explain:

If you are currently under the care of a physician for a continuing health problem, please give your physician(s) name(s) and phone number(s):

Patient's Name: _____

What do you consider to be your strengths?

Briefly describe the problems and reasons that brought you here:

Briefly list goals of your treatment here; that is, what you would like to achieve and/or see happen by coming here for care:
