

Dr. Ann C. McDaniel

Dr. Ann McDaniel PsyD LMHC NCC MAC NBCCH SAP
Licensed Mental Health Counselor
Certified in Sex Therapy, Hypnotherapy & Addictions
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Date: _____

Patient Name: _____ SSN: _____ - _____ - _____
Last First M.I.

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Ext: _____

Other Phone: (____) _____ E-mail: _____

Gender: Male Female Date of Birth: _____ - _____ - _____

Marital Status: _____ Children: _____

Others Living in the Home: _____

Employer: _____

Position: _____ How Long? _____

Insurance Company: _____

Name Insured/Relationship: _____

Insured's Date of Birth: _____ Insured's SS#: _____

Referral Source: _____

Educational Level (Highest Grade Completed): _____

- | | |
|--|---|
| <input type="checkbox"/> less than high school | <input type="checkbox"/> some college |
| <input type="checkbox"/> some high school | <input type="checkbox"/> college graduate |
| <input type="checkbox"/> high school graduate | <input type="checkbox"/> post-graduate work |

Military Service: No If Yes, Status:
 Yes Active Honorable Discharge
 Medical Discharge Dishonorable Discharge

Religion (optional): _____

Primary Care Physician: _____ Phone: _____

Do you have any significant health problems? _____

List any medications/dosages you are currently taking: _____

Do you have any allergies? _____

Have you been in therapy before? _____ When? _____

Name of Therapist: _____

Issues Addressed: _____

In Case of Emergency, Contact:

Name: _____ Relationship: _____

Phone: _____

If patient is minor:

Mother (or Guardian)

Father

Name: _____

Address: _____

(H) Phone: _____

(W) Phone: _____

Additional Information: