Laura M. Horsch, Ph.D.
Licensed Clinical Psychologist
CA PSY#22245

DEMOGRAPHIC INFORMATION FORM

Patient Name: ______________________________________ Today's Date: ____________

Address: ____

Age: ______ Date of Birth: ___________________

Grade Level: ________ Name of School: _______________________________________

Name & Location of Physician: ____

Current Medications ____________________ Dosage ______________ Purpose________________

____

____

____

(use reverse side for additional medication listings)

Parents' Names: ____

Home Phone: ______________________________________ Okay to leave message? Y N

Work Phone : ______________________________________ Okay to leave message? Y N

Cell Phone: _______________________________________ Okay to leave message? Y N

Email: ____ Okay to send email? Y N

Who referred you here? ____

Please list any previous mental health providers the patient has visited:

Name ______________ Dates ________________ Contact Information ____________________

____

____

____

(use reverse side for additional mental health listings)

855 El Camino Real, Menlo Park, CA 94025 650-206-2329 laura@laurahorsch.com