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ADULT INFORMATION SHEET

NAME: _____ **DATE:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **CELL PHONE:** _____

EMAIL: _____

BIRTH DATE: ____ \ ____ \ ____ **AGE:** _____

OCCUPATION: _____ **HOW LONG:** _____

PLACE OF EMPLOYMENT: _____ **EDUCATION:** _____

ADDRESS: _____ **PHONE:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

IS IT OKAY TO LEAVE A MESSAGE AT THE NUMBERS PROVIDED? YES NO

IS IT OKAY TO EMAIL YOU? YES NO

.....
SPOUSE / SIGNIFICANT OTHER

NAME: _____ **BIRTH DATE:** ____ \ ____ \ ____ **AGE:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **CELL PHONE:** _____

EMAIL: _____

PLACE OF EMPLOYMENT: _____

WORK PHONE: _____ **EDUCATION:** _____

MARITAL STATUS: _____ **YRS.** _____ **LENGTH OF RELATIONSHIP** _____

CHILDREN

BIRTH DATE

AGE

SEX

GRADE

PRIMARY CARE PHYSICIAN: _____

MEDICATION (INCLD. DOSAGE) & NAME OF PRESCRIBING DOCTOR:

MEDICAL CONDITIONS OR DIAGNOSIS: _____

PREVIOUS THERAPY, BRIEF REASON FOR TREATMENT AND TERMINATION: -

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

NAME: _____ **HOME PHONE:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

CELL PHONE: _____ **WORK PHONE:** _____

RELATIONSHIP: _____

I WAS REFERRED BY: _____



I AGREE TO BE RESPONSIBLE FOR ALL FEE'S INCURRED BY ME OR ON MY BEHALF FOR SERVICES RENDERED BY CRYSTAL L. STEVENSON, M.A., L.P.C. I UNDERSTAND THAT PAYMENT FOR SERVICES ARE DUE WHEN RENDERED.

I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE INFORMED CONSENT \ INFORMATION SHEET CITING THE PROCEDURES, SESSIONS, PRIVACY RULES, FEES, INSURANCE AND REFERRALS AS STANDARD POLICY AND I AGREE TO THE TERMS SET OUT THEREIN. I UNDERSTAND THAT IF A SUIT IS FILED TO COLLECT ANY UNPAID BALANCE ON MY ACOUNT, I AGREE TO PAY THE REASONABLE ATTORNEY'S FEES FOR SUCH PROCEDURES AND I AGREE VENUE IS ACCEPTABLE IN TRAVIS, COUNTY, TEXAS

**PATIENT SIGNATURE
CONSERVATOR, OR
PARENT**

DATE