DR. MIKOL S. DAVIS
Clinical Psychology

1703 Fifth Street, Suite 101
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CONFIDENTIAL CLIENT INFORMATION (page I of 2)

Welcome to my practice. Please fill out the following questions as completely as possible.

Client's Name	Ms. Mrs. Mr. Last First Middle	Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other
Client's Address	Street	
	City State *Zip code*	
Phone	Home- ( ) Work: ( )	
	Age Birthdate. Birthplace.	
Education	No. of years: Degree: Field:	
	– Current religion	
Spouse	Name: Age: Occupation: Years Married:	
Children	Name Age / Name age / Name Age	
Were you raised by: Both parents?	Single parent? Relative? Other?	
Father's name	Age Occupation	
Mother's Name	Age: Occupation.	
Brothers and sisters (including yourself):	*birth order Name.* Age / Name	
Name Age	*Name* Age / Name Age	

In your family was there a history of: ☐ Alcoholism? ☐ Substance abuse? ☐ Mental illness?
☐ Prolonged physical illness? What kind?

Current *medications*

Significant medical problems:

Have you had previous psychiatric care and/or counseling ☐ yes ☐ No
If yes, give- Name **of doctor** Seen from

Have you ever been hospitalized for substance abuse, alcoholism, eating disorders, or other psychiatric disorders?
☐ Yes ☐ No Details:

CONFIDENTIAL CLIENT INFORMATION (page 2 of 2)

Client or Guardian employed by:			
Employer's address:			
City:	State:	Zip:	Phone ( )
Driver's License No.		Social Security No.	
City:	State:	Zip:	Phone ( )
Spouse employed by:			
Employer's address:			
City;	State	Zip	Phone ( )
Name of company			
Driver's License No.		Social Security No	
City;	State:	Zip	Phone ( )

1, _____ . understand and agree to pay DR. Mikol Davis the amount of
(Person responsible for payment)

$ $250 at the conclusion of each 50 -minute consultation.

I understand that I am responsible for payment for consultations not canceled 24 hours in advance. Payment for services is rendered at the conclusion of the consultation unless other arrangements have been made. I understand that I am responsible for all payments.

Client's Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

I will be happy to discuss my fees, schedule of payments, or any other questions relating to billing or if you wish please provide your credit card number and it will be billed at the end of the month. Please do not hesitate to ask.