

# Adult Information Sheet

F. Sean Redeker MA, LPC, CI, NCC

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*Instructions: Complete the form, print 2 copies, and sign both. Keep a copy for your records.*

## Personal Information

<b>Social Security Number</b>	<b>Name: Last</b>	<b>First</b>	<b>Middle</b>
- -			
<b>Address: Street</b>		<b>City</b>	<b>State</b> <b>Zip</b>
<b>Phone Number:</b>	<b>Work Number:</b>	<b>Cellular Number:</b>	<b>Private E-mail Address:</b>
- -	- -	- -	
<b>Birth Date:</b>	<b>Age:</b>	<b>Marital Status</b>	<b>Length of Relationship</b>
/ /		Single	yrs   mo.

## Employment:

<b>Occupation:</b>	<b>Place of Employment</b>
<b>Address: Street</b>	<b>City</b> <b>State</b> <b>Zip</b>
<b>Education:</b>	<b>Length of Employment:</b>
	yrs   mo.

## Spouse/Significant Other

<b>Social Security Number:</b>	<b>Name: Last</b>	<b>First</b>	<b>Middle</b>
- -			
<b>Address: Street</b>		<b>City</b>	<b>State</b> <b>Zip</b>
<b>Phone Number:</b>	<b>Work Number:</b>	<b>Place of Employment:</b>	<b>Occupation:</b>
- -	- -	- -	
<b>Birth Date:</b>	<b>Age</b>	<b>Education:</b>	<b>Length of Relationship</b>
/ /			yrs   mo.

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## Children Information

Name:	Age	Sex	Grade
		M	
		M	
		M	
		M	
		M	

## Medical Information

**Family Physician or Treatment Center**

**Past Medications (Excluding Antibiotics and O.T.C. Medication):**

**Current Medications:**

**Medical Conditions or Diagnosis:**

**Prior Treatments:**

## Emergency Contact Information

<b>Name:</b>	<b>Relationship</b>		
<input type="text"/>	<input type="text"/>		
<b>Address: Street</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Phone Number:</b>	<b>Cellular Number:</b>		
<input type="text"/>	<input type="text"/>		
<b>Referred by</b>			
<input type="text"/>			

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**I AGREE TO BE RESPONSIBLE FOR ALL FEE'S INCURRED BY ME OR ON MY BEHALF FOR SERVICES RENDERED BY F. SEAN REDEKER, MA, LPC, CI, NCC. I UNDERSTAND THAT PAYMENT FOR SERVICES ARE DUE WHEN RENDERED.**

**I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE INFORMATION & CONSENT FOR TREATMENT 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 THE VENUE IS ACCEPTABLE IN WILLIAMSON, COUNTY, TEXAS**

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**PATIENT SIGNATURE  
CONSERVATOR, OR  
PARENT**

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**DATE**