JENNIFER ROBERTSON, Psy.D.
LICENSED PSYCHOLOGIST
ADULT ADHD CENTER OF WASHINGTON

1801 CONNECTICUT AVE NW, SUITE 300
WASHINGTON, DC 20009

15701 CRABBS BRANCH WAY
ROCKVILLE, MD 20855

CLIENT INFORMATION FORM

Full Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender:_____

Current Address:_____
(Street) (City) (State) (Zip code)

Permanent Address, if applicable:_____

Marital/Partnered Status: _____If married/partnered, how long together?_____

Age of Partner?_____Gender of Partner?___Name of Partner?_____

Name(s) and Age(s) of children, if any?_____

Employer: _____ Occupation: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Personal email address_____

May I email you to (re)schedule appointments? Yes☐ No☐

May I call you to (re)schedule appointments? (please circle preferred contact number above)

Home: Yes ☐ No ☐**Work:** Yes ☐ No ☐ **Cell:** Yes ☐ No ☐**Text OK?** Yes☐ No ☐

May I leave a message on this number? Yes ☐ No ☐

May I leave a message with someone answering this number? Yes ☐ No ☐

What is your preferred method of contact:_____

Please list any restrictions on contact: _____

***Whom may I contact in case of an emergency*?**

Name: _____ Relationship: _____

Phone: _____ Alternate phone: _____

How did you hear about my practice? (If via internet, which site first, if you recall?)

_____

If referred by a health professional, may I thank this person, as a professional courtesy? Yes ☐ No ☐

Referred to Practice by: _____

Phone and/or Email: _____

In the space below, please briefly describe the reason(s) for seeking an evaluation:

_____

_____

Have you ever had an in-depth psychiatric or psychoeducational assessment? (In school or from a psychologist/psychiatrist?) Yes □ No □

If yes, when and where? _____

Have you ever had previous psychotherapy or counseling? Yes □ No □

If "yes," by whom and when? _____

Reason for treatment? _____

If you have ever received a mental health diagnosis, what diagnosis?_____

Are you currently taking any psychotropic medication (e.g. antidepressants, anti-anxiety, attention/stimulants,or sleep medications?)

Yes □ No □ *If yes, list medication(s) and current dosage(s):* _____

_____

Name of prescribing Doctor: _____Phone: _____

Please list any health problems _____

List any medication(s) and current dosage(s):

_____

Have you ever been psychiatrically hospitalized? Yes □ No □ *If so, when and where?*

_____

I hereby give my consent for a two to three session psychological evaluation with Jennifer Robertson, Psy.D., DC License # PSY1000492. I understand that I may or may not receive a diagnosis of Attention Deficit/Hyperactivity Disorder as a result of this evaluation. I understand I may be referred to another Psychologist if an in-depth, full Psychoeducational testing is needed for accommodations or as a suggestion for a particularly complex diagnostic presentation. Dr. Robertson will review and offer treatment options, if a diagnosis is made, or is provisionally made. As a Psychologist, Dr. Robertson cannot prescribe medications, therefore, you will be referred to an M.D. should you decide to seek treatment with psychotropic medications, such as stimulants. Please ask Dr. Robertson about any questions you may have about this evaluation process.

Client Signature **Date**

Dr. Robertson complies with HIPAA standards. A full Privacy Practices document is available upon request.
24 hours notice is required for appointment cancellations or reschedules. The full $225 fee for the scheduled session will be charged if less than 24 hours notice is given and the appointment cannot be rescheduled within the same work week.