

**Kimberley Taylor, Psy.D.**  
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**Patient Information**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Business Address \_\_\_\_\_

Business Phone \_\_\_\_\_ Birth Date \_\_\_\_\_

Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_

Referred by: \_\_\_\_\_

Medical Insurance \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Medical Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Last check up or visit \_\_\_\_\_

Major Medical History \_\_\_\_\_

Medications/Dosage/Reason \_\_\_\_\_

Previous Therapy (Therapist, year, length) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Spouse \_\_\_\_\_ Phone \_\_\_\_\_

Reason for Coming to Therapy \_\_\_\_\_

*Please use back of page if you need more room*