



MARSHALL UNIVERSITY PSYCHOLOGY CLINIC
INITIAL PHONE CONTACT

Date of Contact: _____

Fee: _____

Name: _____

Child's Name: _____

Gender: M F (please circle)

Child's Gender: M F (please circle)

Age: _____

Child's Age: _____

Address: _____

Telephone Number: _____ (Home) _____ (Work) _____ (Cell)

What is the best time to call? _____

Is it ok to leave a message? YES NO (please circle)

Email Address: _____ (with client permission – used only for scheduling appts.)

Has contact ever been seen in this clinic before? YES NO (please circle)

If yes, by whom? _____

Are you a: _____ MU Student _____ MU Faculty _____ MU Staff _____ Community Member

Major: _____ Dept: _____ Dept: _____

How did you hear about us? _____

Are you interested in _____ Psychological Testing and/or _____ Therapy
Description of presenting concern:

Contact History
Date Method of Contact Outcome

(Use the back of this form to record further information)

Assigned Clinician: _____	Date: _____	Time: _____
Initials of person taking call: _____	Date: _____	