Kara Goobic, Psy.D.
Licensed Psychologist

Adult ADHD Center of Washington
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Patient Information Form

Date of Initial Appointment:_____

Name of Patient:_____

Name of Parent:_____(If client is less than 18 years of age)

Permission to Leave message at this Number

Cell Phone: _____ ___Yes _____No

Work Phone:_____ ___Yes _____No

Home Phone:_____ ___Yes _____No

Date of Birth:_____

I, _____, give Kara Goobic, Psy.D. permission to communicate with me via email at the following email address) in order to set or change appointments, or in response to phone calls or emails from me.

Email Address: _____

Signature:_____

Address:_____

City_____,

State:_____ Zip Code:_____

Emergency Contact:_____ Cell Phone:_____

Relationship:_____ Home Phone:_____

Work Phone:_____

Who referred you to Dr. Goobic? _____

Are you in treatment with a psychiatrist, psychologist, or psychotherapist?

Yes _____ No _____

If so, please provide name and phone numbers: _____