HRA PSYCHOLOGICAL SERVICES

Psychological Evaluation Intake

Type of Evaluation: □Court Order □Attorney Referral □Physician □Self-Referred

Person to be Evaluated: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Age: _____ DOB: _____ Gender: □Male □Female □Other: _____

Phone: _____ Email: _____

Purpose of Eval: _____

Report is needed by what date? _____ Party Responsible for Payment: _____

For Court Orders Only
Order provided: □Prior to Evaluation □At Time of Appointment
Court Date: _____ Report to be submitted to whom? _____
Address for submitting report: _____
NOTE: Payment is due in full at the time of service. Thank you.

For Minors Only
Parent/Guardian Name: _____ Parent/Guardian Name: _____
Parent's Status: □Married □Divorced □Separated □Single □Widowed □Other: _____
Currently living with: □Parent(s) □Foster Parent(s) □Residential Facility
Name of Foster Parent(s) or Residential Facility (if applicable): _____

Person requesting evaluation: _____

Referral Name / Organization: _____

Report submitted to whom? Name: _____

Address: _____ Email: _____