



Brian Cross, Ph.D., PLLC, Licensed Clinical Psychologist

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Client Information

LAST NAME _____ FIRST NAME _____ M. I. _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____

TELEPHONE: HOME (_____) _____
WORK (_____) _____ CELL (_____) _____

EMAIL _____ BEST WAY TO CONTACT?: _____
AGE _____ DATE OF BIRTH _____ GENDER: M / F
SOCIAL SECURITY NO. (Last 4 digits only) _____

EMERGENCY CONTACT: Whom should contact if I cannot reach
you? _____
Relationship: _____ Telephone: _____

MARITAL STATUS: (circle) SINGLE PARTNERED/MARRIED DIVORCED WIDOWED

EMPLOYMENT STATUS: (circle) FULL-TIME.... PART-TIME
RETIRED.....DISABLED.....UNEMPLOYED.....STUDENT

EMPLOYER'S NAME: _____
EMPLOYERS ADDRESS _____
CITY: _____ STATE: _____ ZIP _____

PRIMARY CARE PHYSICIAN: _____
ADDRESS: _____
CITY _____ STATE _____ ZIP _____
TELEPHONE: _____

May I contact your physician to coordinate medical treatment issues as needed? YES NO

REFERRAL SOURCE: _____
May I contact the source to thank him/her?(circle) YES NO

I understand that a colleague of Brian Cross, Ph.D., may need to access this information in case of
an emergency. Signature and Date---Thanks.