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New Client Information (page 1 of 5)

**Please Print Clearly**

Date: \_\_\_\_\_

NAME: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ YOUR EDUCATION BACKGROUND: \_\_\_\_\_

SINGLE  MARRIED  WIDOWED  DIVORCED HOW MANY YEARS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYED BY: \_\_\_\_\_

NAMES & AGES OF CHILDREN: \_\_\_\_\_

SPOUSE NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

SPOUSE EDUCATION BACKGROUND: \_\_\_\_\_ SPOUSE BIRTHDATE: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

HAVE YOU HAD PSYCHOTHERAPY OR BEEN HOSPITALIZED FOR EMOTIONAL ISSUES?  YES  NO

IF YES, WITH WHOM AND WHEN: \_\_\_\_\_

DO YOU HAVE MEDICAL INSURANCE COVERING PSYCHOLOGICAL SERVICES?  YES  NO

DO YOU TAKE PRESCRIPTION DRUGS?  YES  NO IF YES, WHAT KIND AND HOW OFTEN: \_\_\_\_\_

DO YOU TAKE RECREATIONAL DRUGS?  YES  NO IF YES, WHAT KIND AND HOW OFTEN: \_\_\_\_\_

DO YOU DRINK ALCOHOL?  YES  NO IF YES, HOW OFTEN AND WHAT AMOUNT: \_\_\_\_\_

INFORMATION ABOUT OUR FEES AND CANCELLATION POLICY: Our office expects co-payments and applicable deductible payments to be made at the time of the appointment. We request a 48 hour notification if you need to cancel an appointment. Experience has taught us that with a 48 hour notice we may be able to fill that appointment hour. If you cancel with less than a 48 hour notice, you will need to pay the full fee of \$120.00 for this reserved time. All returned checks will incur a charge of \$25.00.

Your Initials: \_\_\_\_\_