CLIENT INFORMATION

Please complete both sides of this form. All information is confidential

Client Name_____ Date:_____

Address: _____City_____State_____Zip Code_____

Home/Cell Phone #: _____ Work Phone #_____

Email address: _____ Date of Birth_____ Age _____

Referred by: _____ Marital Status _____Employer _____ Occupation: _____

Name of emergency Contact Person **you give permission to contact**:_____ Phone number:_____

Insurance Information

Relationship to insured _____self _____Spouse _____ Child _____ Other

Insurance Subscriber's name (if not self) _____ Date of Birth: _____

Subscriber's Address: _____City_____State_____ Zip Code _____

Subscriber's Phone Number: _____ Subscriber's Employer _____

Insurance Plan Name: _____ Member ID Number _____ Group Number _____

Responsible Party for Payment

Responsible party for payment (if different from above) _____

Responsible Party Address: _____ Phone #: _____

Please complete this form as it pertains to the client

Why are you here today?

_____

_____

How long has this been going on? _____ Less than 6 months _____ More than 6 months

_____

_____

Previous Mental Health History

Have you received mental health services before? _____ No _____ Yes _____Voluntary _____Involuntary If yes, where and when:

_____

_____

Have you ever had a psychiatric hospitalization? _____No ____Yes ____ Voluntary ____ Involuntary If yes, where and when:

_____

_____

Is there a family history of mental health problems? ____ No ___ Yes If Yes, please explain: _____

_____

Please complete side two. Thanks!

Medical/Dental Information

Do you have any current medical/dental problems? (Please list) _____
_____
_____

Have you had any major medical/dental problems in the past? (Please describe) _____
_____

Who Is your primary care provider? _____ Location: _____ Phone # _____
When did last see him/her? _____
Please list all current medications (including non-traditional medications, i.e. herbs, vitamins, other over the counter meds)

Medication Name	Dosage/Time	Reason	Start Date	Prescriber	Currently Taking?
					___ Yes ___ No
					___ Yes ___ No
					___Yes ___ No
					___ Yes ___ No
					___ Yes ___ No

Do you have allergies? ___ No ___Yes
List allergies (include food and medications) and the type of reaction experienced:

1. _____ 3. _____
2. _____ 4. _____

Substance Use: _____ N/A

___ Caffeine: Amount: _____ Frequency: _____ Duration: _____
___ Tobacco: Amount: _____Frequency: _____ Duration: _____
___ Alcohol: Amount: _____Frequency: _____ Duration: _____ Type: _____
___ Prescription Drugs (abuse only): Amount: _____ Frequency: _____ Duration: _____ Type: _____
___ Inhalants (abuse only): Amount _____ Frequency: _____ Duration: _____ Type: _____
___ Illegal Drugs, Type: _____ Method of Administration: _____
Type: _____ Method of Administration: _____
___ Other _____

Please list Family/Household Members

Name	Age	Relationship to Client	Where Living
			____ At Home ____ Out of Home
			____ At Home ____ Out of Home
			____ At Home ____ Out of Home
			____ At Home ____ Out of Home
			_____ At Home _____ Out of Home
			____ At Home ____ Out of Home
			____ At Home ____ Out of Home

Please list other important people involved in your life: _____
_____
Spiritual/Religious Activity: ____ No ____ Yes, Specify _____

Education: ___ Graduate Degree ___ Undergraduate Degree ___ Associate/Vocational/Tech Degree ___ High School/GED
___ Less than High School Specify last grade completed: _____
Special Education (specify subjects):_____

Thank you for completing this form!