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PUTTING FIRST RESPONDERS AND THEIR FAMILIES FIRST

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NEW CLIENT INFORMATION

Referred By: _____

I. Client Information:

Name: _____ Date: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security #: _____ Male Female

In case of emergency, please notify:

Name: _____ Telephone: _____ Relationship: _____

Please complete this section for others residing in the client's home:

Name	Date of Birth	Age	Gender	Relationship To Patient

II. Insurance:

Policy Holder's Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security #: _____ Male Female

Insurance Company: _____ Authorization #: _____

Number of Sessions Authorized: _____ Co-pay: _____ Policyholder or Subscriber ID#: _____

Employer: _____ Job Title: _____

If patient is a dependent, what is his / her relationship to policyholder: _____

III. Optional Information:

Ethnic Background:

- American Indian or Alaskan Native
- Asian or Pacific Islander
- African-American
- Hispanic
- Caucasian
- Other: _____

Highest Education Level:

- No High School
- Some High School
- High School Diploma
- Some College / Technical School
- Bachelor's Degree
- Master's Degree
- Doctorate

IV. Educational / Occupational Status (check all that apply):

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Currently employed | <input type="checkbox"/> Full-Time |
| <input type="checkbox"/> Self Employed | <input type="checkbox"/> Part-Time |
| <input type="checkbox"/> Homemaker | <input type="checkbox"/> Student |
| <input type="checkbox"/> Retired | <input type="checkbox"/> Unemployed |
| <input type="checkbox"/> Disability | |

V. Health Status:

Current or chronic medical issues: _____

Prior medications taken for emotional / substance abuse problems:

Name:	Name:	Name:
Dose (mg):	Dose (mg):	Dose (mg):
Frequency:	Frequency:	Frequency:

Current medications taken for emotional / substance abuse problems:

Name:	Name:	Name:
Dose (mg):	Dose (mg):	Dose (mg):
Frequency:	Frequency:	Frequency:

Other medications: _____

Primary Care Doctor: _____ Telephone #: _____

VI. Mental Health:

	Therapist / Facility	Date	Duration	Outcome
Prior Therapy	1)	1)	1)	1)
	2)	2)	2)	2)
Prior Hospitalization	1)	1)	1)	1)
	2)	2)	2)	2)

VII. Problem Category: (please check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Emotional Health | <input type="checkbox"/> Abuse / Violence |
| <input type="checkbox"/> Substance Use / Abuse | <input type="checkbox"/> Health Related |
| <input type="checkbox"/> Suicide Risk | <input type="checkbox"/> Children |
| <input type="checkbox"/> Marital / Relationship Issues | <input type="checkbox"/> Financial |
| <input type="checkbox"/> Other Family Issues | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Other _____ |

Please briefly describe why you are choosing to enter treatment at this time: _____

