Patient Information Date of Contact: _____

First Name: _____ **Middle:** _____ **Last:** _____

Sex: M or F **DOB:** _____ **SSN:** _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

ER Contact & Relationship: _____ **ER Phone:** _____

Appointment Reminders: Phone Number _____ Text? Yes No

Race: White
Black
Hispanic
Other

Referral: Self
Family/Friend
Doctor
School

Education: GED/Diploma
2yr Degree
4yr Degree
Last Grade Completed ____

School Based Therapy? Yes No School District: _____

Employment:
Full Time
Part Time
Unemployed
Disabled
Retired
Student

Employer: _____ **EAP:** Yes No

Occupation: _____

Marital Status:
Single
Married
Divorced
Separated
Widowed

Spouse/Domestic Partner's Name: _____

Spouse Employer: _____ **EAP:** Yes No

Occupation: _____

Number in Household: _____ **Annual Income:** _____

If client is a child, who does child live with: Mother Father Both Parents Other _____

Father's Name:_____ Address: _____

Mother's Name: _____ Address: _____

Have you been seen for Mental Health before? Yes No **Location**: _____

Medical Doctor: _____ **Pharmacy**: _____

Presenting Problem: _____

_____

_____

_____

Insurance Information

Primary

Insurance Company: _____ Phone #: _____

Insurance ID #: _____ Group #: _____

Cardholder's Name: _____ Relationship: _____ DOB: _____

Effective Date: _____ Copay: _____ Deductible: _____ Co-insurance: _____

Secondary

Insurance Company: _____ Phone #: _____

Insurance ID #: _____ Group #: _____

Cardholder's Name: _____ Relationship: _____ DOB: _____

Effective Date: _____ Copay: _____ Deductible: _____ Co-insurance: _____

Tertiary

Insurance Company: _____ Phone #: _____

Insurance ID #: _____ Group #: _____

Cardholder's Name: _____ Relationship: _____ DOB: _____

Effective Date: _____ Copay: _____ Deductible: _____ Co-insurance: _____

----------**Office Use Only**----------

Intake Appointment : Date: _____ Time: _____ Provider: _____

Medication Appointment : Date: _____ Time: _____ Provider: _____

Contact :

Date: _____ Time: _____ Phone #: _____ Response: _____

Date: _____ Time: _____ Phone #: _____ Response: _____

Date: _____ Time: _____ Phone #: _____ Response: _____

_____

_____

_____

_____