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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 #:_____
Address:_____ City:_____ State:_____
Number of Sessions Authorized:_____ Co-pay:_____ Policy Holder/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):

- ☐ Currently employed
- ☐ Self Employed
- ☐ Homemaker
- ☐ Retired
- ☐ Disability
- ☐ Full-Time
- ☐ Part-Time
- ☐ Student
- ☐ Unemployed

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) 2)	1) 2)	1) 2)	1) 2)
Prior Hospitalization	1) 2)	1) 2)	1) 2)	1) 2)

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

- ☐ Emotional Health
- ☐ Substance Use / Abuse
- ☐ Suicide Risk
- ☐ Marital / Relationship Issues
- ☐ Other Family Issues
- ☐ Eating Disorder
- ☐ Abuse / Violence
- ☐ Health Related
- ☐ Children
- ☐ Financial
- ☐ Legal
- ☐ Other_____

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