Screening Information

SCREENING INFORMATION

Please Print Clearly **THIS SHEET MUST BE FILLED IN COMPLETELY** Readmit: __Yes __No

Date_____ Client's Social Security #_____ Case #_____

Client's First Name_____ Last Name_____ MI_____

Address_____ City_____ State_____ Zip_____

Telephone (Home)_____ (Work)_____

Birthdate____/____/____ Age_____ Gender __F __M Race_____

Name of Spouse/Guardian_____ Phone_____

Address_____ City_____ State_____ Zip_____

Person Responsible for Payment_____ Soc. Sec. #_____

Signature of Person Responsible for Payment **X**_____ (Must be signed for services to begin)

Emergency Information

In case of emergency, contact:

Name (1) _____ Relationship_____ Phone_____Work_____

Address_____ City_____ State_____ Zip_____

Name (2) _____ Relationship_____ Phone_____Work_____

Address_____ City_____ State_____ Zip_____

Physician_____ Phone_____

Address_____ City_____ State_____ Zip_____

Psychiatrist_____ Phone_____

Address_____ City_____ State_____ Zip_____

Other Physicians_____ Phone_____

Current Medications_____

Allergies_____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place_____ Phone_____ Hrs____

Spouse: Place_____ Phone_____ Hrs____

Insurance Information

Primary Insurance_____ Secondary Insurance_____

Phone_____ Phone_____

Contract/ID#_____ Contract/ID#_____

Group/Acct#_____ Group/Acct#_____

Subscriber_____ Subscriber_____

Subscriber Date of Birth _____ Subscriber Date of Birth_____

Client's relationship to Subscriber Client's relationship to Subscriber

__Self __Spouse __Child __Other_____ __Self __Spouse __Child __Other_____

Referral Source

How did you hear of our clinic (or from whom)?_____

Address_____ City_____ State_____ Zip_____

Phone_____ Relationship to referral source_____

New Patient Health Information

Patient Name:	**Date of Birth:**
Name of person completing this form (if different from patient) and relationship to the patient:	
Insurance Information	
Company:	**Policy Number:**
Emergency Contact Person:	
Emergency Contact Phone Number:	
Date of Appointment:	

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of the quality of care and that the information you provide will be kept confidential.

What problems or concerns are you experiencing that have prompted you to come to this clinic?

What are your goals & hopes for treatment:

Have you been in the hospital for psychiatric illness in the past? No ☐ Yes ☐
If yes by where, when and for how long:
Have you been treated by a psychiatrist in the past? ☐ No ☐ Yes
If yes by whom and for how long:

List of Present Medications

(To ensure accuracy, please list this information directly from your prescription bottles/containers if available. Please include vitamins, herbs and over the counter medications.)

Medication Name	Dosage	Prescribing Doctor

Please list any medication you have an allergy to and the type of allergy (e.g. skin rash, trouble breathing, anaphylaxis, etc)

_____

_____