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

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_____

List Prior Psychological/Psychiatric Treatment_____

_____

Medical Issues/Diagnoses _____

List Surgeries_____

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_____

Phone_____

Contract/ID#_____

Group/Acct#_____

Subscriber_____

Subscriber Date of Birth _____

Client's relationship to Subscriber

Self __Spouse __Child __Other_____

Secondary Insurance_____

Phone_____

Contract/ID#_____

Group/Acct#_____

Subscriber_____

Subscriber Date of Birth_____

Client's relationship to Subscriber

Self __Spouse __Child __Other_____