



Screening Information

THIS SHEET MUST BE FILLED IN COMPLETELY

Please Print Clearly

Date: ___/___/_____ Client's Social Security #: _____ / _____ / _____

Client's First Name: _____ Last Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone (Home): _____ (Work): _____

Email Address: _____

Birthdate: ___/___/_____ Age: _____ Gender: _____ Race: _____

Name of Spouse/Guardian: _____ Phone: _____

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

Person Responsible for Payment: _____ Soc. Sec. #: _____ - _____ - _____

Signature of Person Responsible for Payment: _____

(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 Physician: _____ Phone: _____

Current Medications: _____

Allergies: _____

How did you hear of my practice? _____

Address _____

City: _____ State: _____ Zip: _____

Phone _____

Relationship to referral source _____

(Revised 10/2013)