

**CLIENT INFORMATION**

Chart #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

For Confidential Use Only

Legal Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City State Zip Code

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Leave Message? Yes No Leave Message? Yes No Leave Message? Yes No

E-Mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and phone number

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer/School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of years (or highest level of) education \_\_\_\_\_\_\_\_\_

Gender \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship (or Couple) Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race/Ethnicity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name/Address of financially responsible party if other than client *(For minors or anyone using 3rd party, non-insurance payor.)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If client is a minor, name/address/phone of custodial parent, if different from name above \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gross annual family income $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per year Number dependent on this income \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family and household members (includes housemates, spouse, partner and all children *(Continue on back if needed.)* Clarify if client is a minor from two households *(Include any different last names.)*

Name Age Gender Relationship Living with you?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

Religion \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of worship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it important for you to have spirituality included in your therapy? Yes No

PLEASE CONTINUE ON PAGE 2

****

Chart #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

For Confidential Use Only

|  |  |
| --- | --- |
| Chief Complaint: |  |
| History of Present illness: |  |
| Past Psychiatric/Psychological History: |  |
| Past Medical History: |  |
| Past Surgical History: |  |
| Allergies: |  |

**Current Medication List**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | Dose | Frequency | Prescriber | Reason |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Past Medication List**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | Dose | Frequency | Prescriber | Reason |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

PLEASE CONTINUE ON PAGE 3

**Drug/Alcohol Assessment**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Which substances are currently used | Method of use (oral, inhalation, intranasal, or injection) | Amount of Use | Frequency of use (times/month) | Time period of use | Which substances have been used in the past |
| \_\_ Alcohol |  |  |  |  | \_\_ Alcohol |
| \_\_ Caffeine |  |  |  |  | \_\_ Caffeine |
| \_\_ Nicotine |  |  |  |  | \_\_ Nicotine |
| \_\_Opiates |  |  |  |  | \_\_Opiates |
| \_\_Marijuana |  |  |  |  | \_\_Marijuana |
| \_\_ Cocaine/Crack |  |  |  |  | \_\_ Cocaine/Crack |
| \_\_ Methamphetamines |  |  |  |  | \_\_ Methamphetamines |
| \_\_Inhalants |  |  |  |  | \_\_Inhalants |
| \_\_ Stimulants |  |  |  |  | \_\_ Stimulants |
| \_\_ Hallucinogens |  |  |  |  | \_\_ Hallucinogens |
| \_\_ Other: |  |  |  |  | \_\_ Other: |

**Suicidal/Homicidal Ideation**

|  |  |  |
| --- | --- | --- |
| Is there a suicide risk? | \_\_\_No \_\_\_ Yes | \_\_\_ Patient refused to answer |
| Previous Attempt? \_\_No \_\_ Yes | Current Plan? \_\_ No \_\_ Yes | Means? \_\_ No \_\_ Yes |
| Intent? \_\_ No \_\_ Yes | Lethality of Plan? \_\_ No \_\_ Yes |  |
| Do you have thoughts of harming others? \_\_ No \_\_ Yes | Current Plan? \_\_ No \_\_ Yes | Means to carry out plan?  \_\_ No \_\_ Yes |
| Intent? \_\_ No \_\_ Yes | Lethality of Plan? \_\_ No \_\_ Yes |  |
| High risk behaviors? | \_\_\_ None \_\_\_ Cutting | \_\_\_ Anorexia/Bulimia |
|  | \_\_\_ Head banging | \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Abuse Assessment**

|  |
| --- |
| In the past year have you been hit, kicked, or physically hurt by another person? \_\_ No \_\_ Yes  Explain: |
| Are you in a relationship with someone who threatens or physically harms you? \_\_ No \_\_ Yes  Explain: |
| Have you ever been forced to have sexual contact that you were not comfortable with? \_\_ No \_\_ Yes  Explain: |
| Have you ever been abused? \_\_No \_\_ Yes  If yes, describe by whom, when and how. |

CONTINUE ON PAGE 4

**Family/Social History**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Born/Raised | |  | | |
| Siblings | \_\_\_\_\_\_ # of brothers | | | \_\_\_\_\_\_ # of sisters |
| What is your birth order? | | | \_\_\_\_\_ of \_\_\_\_\_ children | |
| Who primarily raised you? | | |  | |
| Describe marriages or significant relationships | | |  | |
| Number of Children: \_\_\_\_\_ | | | | |
| Current living situation: | | | | |
| Military history/type of discharge: | | | | |
| Support/social network: | | | | |
| Significant life events: | | | | |

**Family History of Mental Illness**

|  |  |
| --- | --- |
| Relative | Mental Illness |
|  |  |
|  |  |
|  |  |

**Employment**

|  |
| --- |
| What is your current employment status? |
| Do you like your job? |
| Will this job likely be done on a long-term basis? |
| Do you get along with your co-workers? |
| Do you perform well at your job? |
| Have you ever been fired from the job? Yes No  If yes, explain |
| How many jobs have you had in the last five years? |

**Education**

|  |
| --- |
| Highest grade completed: |
| Schools attended: |
| Discipline problems: |

**Current Legal Status**

|  |  |
| --- | --- |
| \_\_\_\_ No legal problems | \_\_\_\_ Parole |
| \_\_\_\_ Probation | \_\_\_\_ Charges Pending |
| \_\_\_\_ Previous jail | \_\_\_\_ Has a guardian |

CONTINUE ON PAGE 5

PAGE 6

**Developmental History**

|  |
| --- |
| Describe the childhood: \_\_\_\_ Traumatic \_\_\_\_ Painful \_\_\_\_ Uneventful |
| Describe the childhood in relation to personality, school, friends, and hobbies: |
| Describe any traumatic experiences in the childhood: (List the age when they occurred) |

**Spiritual Assessment**

|  |
| --- |
| Religious background: |
| Do you currently attend any religious services? \_\_ No \_\_ Yes  If yes, where? |

**Cultural Assessment**

|  |
| --- |
| List any important issues that have affected your ethnic/cultural background |

**Coping Skills**

|  |
| --- |
| Describe how you cope with stressful situations: |

**Is your coping methods: \_\_\_ adaptive \_\_\_ maladaptive**

**Interests and Abilities**

|  |
| --- |
| What hobbies does the patient have? |
| What is the patient good at? |
| What gives the patient pleasure? |

**Mental Health Status Assessment**

(Describe any deviation from normal under each category)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Arousal/Orientation** | | | | | | | | | | | | | | | | | | | |
| \_\_\_ Alert | | | | \_\_\_ Sleepy | | | | | | | \_\_\_ Attentive | | | | \_\_\_ Unresponsive | | | | |
| \_\_\_ Oriented to Person | | | | \_\_\_ Oriented to Place | | | | | | | \_\_\_ Oriented to Time | | | | \_\_\_ Confused | | | | |
| \_\_\_ Other: | | | | | | | | | | | | | | | | | | | |
| **Appearance** | | | | | | | | | | | | | | | | | | | |
| \_\_\_ Well groomed | | | | \_\_\_ Good eye contact | | | | | | | \_\_\_ Poor eye contact | | | | \_\_\_ Disheveled | | | | |
| \_\_\_ Bizarre | | | | | | | \_\_\_ Poor Hygiene | | | | | | | \_\_\_ Inappropriate dress | | | | | |
| \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| **Behavior/Motor Activity** | | | | | | | | | | | | | | | | | | | |
| \_\_\_ Normal | | | | \_\_\_ Restless | | | | | | | \_\_\_ Agitated | | | | \_\_\_ Lethargic | | | | |
| \_\_\_ Abnormal facial expressions | | | | | | | \_\_\_Tremors | | | | | | | \_\_\_Tics | | | | | |
| \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| **Mood/Affect** | | | | | | | | | | | | | | | | | | | |
| \_\_\_ Normal | | \_\_\_ Depressed | | | | \_\_\_ Flat | | | | | \_\_\_ Euphoric | | | \_\_\_ Anxious | | | | | \_\_\_ Irritable |
| \_\_\_ Liable | \_\_\_ Indifferent | | | | \_\_\_ Careless | | | | | \_\_\_ Inability to sense emotions | | | | | | \_\_\_ Lack of sympathy | | | |
| \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| **Speech** | | | | | | | | | | | | | | | | | | | |
| \_\_\_ Normal | | | \_\_\_ Nonverbal | | | | | | \_\_\_ Slurred | | | | \_\_\_ Soft | | | | | \_\_\_ Loud | |
| \_\_\_ Pressured | | | \_\_\_ Limited | | | | | | \_\_\_ Incoherent | | | | \_\_\_ Halting | | | | | \_\_\_ Rapid | |
| \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| **Attitude** | | | | | | | | | | | | | | | | | | | |
| \_\_\_ Cooperative | | | \_\_\_ Uncooperative | | | | | | \_\_\_ Guarded | | | | \_\_\_ Suspicious | | | | | \_\_\_ Hostile | |
| \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| **Thought Process** | | | | | | | | | | | | | | | | | | | |
| \_\_\_ Intact | | | \_\_\_ Flight of ideas | | | | | | \_\_\_ Tangential | | | | \_\_\_ Concrete | | | | | \_\_\_ Loose | |
| \_\_\_ Circumstantial | | | \_\_\_ Neologisms | | | | | | \_\_\_ Racing | | | | \_\_\_ Word Salad | | | | | \_\_\_ Unable to think abstractly | |
| \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| **Thought Content** | | | | | | | | | | | | | | | | | | | |
| \_\_\_ Normal | | | | | | \_\_\_ Phobia | | | | | | | | \_\_\_ Hypochondriasis | | | | | |
| \_\_\_ Delusions | | | | | | \_\_\_ Obsessive | | | | | | | | \_\_\_ Preoccupations | | | | | |
| \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| **Delusions** | | | | | | | | | | | | | | | | | | | |
| \_\_\_ None | | | \_\_\_ Religious | | | | | \_\_\_ Persecutory | | | | \_\_\_ Grandiose | | | | | \_\_\_ Somatic | | |
| \_\_\_ Ideas of reference | | | | | | \_\_\_ Thought broadcasting | | | | | | | | \_\_\_ Thought insertion | | | | | |
| \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| Hallucinations   |  |  | | --- | --- | | \_\_\_ None | \_\_\_ Auditory hallucinations | | \_\_\_ Visual hallucinations | \_\_\_ Command hallucinations | | | | | | | | | | | | | | | | | | | | |
| \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| **Impulse Control** | | | | | | | | | | | | | | | | | | | |
| \_\_\_ Normal | | | \_\_\_ Partial | | | | | \_\_\_ Limited | | | | \_\_\_ Poor | | | | | \_\_\_ None | | |
| \_\_\_ Frequently participates in activities without planning or thinking about them | | | | | | | | | | | | | | | | | | | |
| **Judgment** | | | | | | | | | | | | | | | | | | | |
| **\_\_\_ Normal** | | | | | | | | | | | **\_\_\_ Poor** | | | | | | | | |

**Insight**

|  |
| --- |
| \_\_\_\_ Normal \_\_\_\_ Poor |
| Is the patient able to meet their basic needs (e.g., food, shelter, medical): |
| \_\_\_ Yes \_\_\_ No |
| If no, describe: |

**Functional Ability**

**(Check the area of concern)**

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_ None | \_\_\_ Daily living activities | \_\_\_ Work | \_\_\_ Finances |
| \_\_\_ School | \_\_\_ Family relationships | \_\_\_Social relationships | \_\_\_Safety |
| \_\_\_ Legal | \_\_\_Cognitive functioning | \_\_\_ Physical health | \_\_\_ Housing |
| \_\_\_ Housing | \_\_\_School | \_\_\_ Impulse Control | \_\_\_ Social skills |

**CONTINUE ON PAGE 7**

|  |
| --- |
| **ADDITIONAL QUESTIONS**  Are you a returning client? \_\_\_ Yes \_\_\_ No How did you learn about EMNS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Did you come because of legal or DHS issues? \_\_\_\_\_\_\_\_ Name of person referring \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **FOR THERAPIST USE**  **Therapist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DX Code \_\_\_\_\_\_\_\_\_\_\_\_\_ Fee \_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_**  **Method of payment \_\_\_\_ Ins\* \_\_\_\_ EMNS Grant Funds \_\_\_\_ EAP \_\_\_\_ 3rd Party Non-insurance Guarantor (i.e., church) \_\_\_\_ Self-Pay**   * **Insurance Information form must be completed double-signed by client, stapled to photocopy of medical card, included with intake paperwork.**   **File: \_\_\_\_ Individual \_\_\_\_ Couple \_\_\_\_ Family (Number of family members) \_\_\_\_ Group**  **If Couple or Family: check one \_\_\_\_ Primary client ( patient for insurance purposes: contact for scheduling) \_\_\_\_ Additional client(s)** |

|  |  |
| --- | --- |
| **Counselor**  **Signature:** | **Date/Time:** |
|  |  |
| **Supervisor**  **Signature:** | **Date/Time:** |

FINAL PAGE 8