Providence Place
CLIENT INFORMATION FORM

DATE: ________________________

NAME: ________________________________ ____________________ ___________________
Last First Middle

ADDRESS: ____ ________________ _____ _________
Mailing Address City State Zip

It is sometimes necessary for us to contact you at one of these phone numbers, but confidentiality prevents us from identifying ourselves. Do we have your permission to identify ourselves as a representative of Providence Place on the phone or answering machine message?
(please initial yes or no following each phone number) **Please Initial**

HOME PHONE (_______) _____________________ ________ Yes _______ No

CELL PHONE (_______) _____________________ ________ Yes _______ No

WORK PHONE (_______) _____________________ ________ Yes _______ No

SOCIAL SECURITY NUMBER ____________________ **DATE OF BIRTH** _______________ **AGE** ________

EMAIL ADDRESS ____

Please Circle All That Apply

GENDER: Male Female

RACE: Caucasian/White African American Asian
Hispanic American Indian Other

CURRENT MARITAL STATUS: Not Applicable Divorced Remarried
Never Married Widowed Unmarried Minor
Married Separated Other ________________

IN CASE OF EMERGENCY, CONTACT:
It may be necessary for us to contact an emergency contact person for you when you are in our offices. This rarely ever happens, and would only happen if you are unable to contact someone yourself.

Name: ____

Address: ____

Phone: ____

Initial here if you do not wish to list an emergency contact person _________

How did you hear about us? ____

Are you court ordered to come to see us? ________ Yes _______ No

Please Select One

LIVING WITH: Alone Spouse/Relative/Family Friends

Foster Home Group Home Care Facility

Nursing Home Mental Health Institution Other ___________

Household Members Currently in the Home	Relationship	Date of Birth	Occupation	Last Grade Completed

Is where you are living safe? ________ Yes ________ No

List of individuals that support you:

Name	Relationship

EDUCATIONAL INFORMATION:

List the schools that you have attended

School	Dates Attended	Grade Completed

OCCUPATIONAL INFORMATION:

Present Occupation:

Not Applicable	Full Time	Part Time	Disabled
Temporarily Disabled	Unemployed (looking)	Unemployed (not looking)	Other
Student Over 18	Homemaker	Retired	

List your last two employers:

Place of Employment	**Dates Worked**	**Occupation**

Have you ever served in the military? ________ Yes _______ No

If yes, when and where did you serve? ____

PRESENTING PROBLEM(S)
Please Circle ALL That Apply

Psychotic	Suicidal	Vocational/employment
Anxiety	Substance Abuse	Coping
Anger Management	Problem with the law	Evaluation Request
Physical Complaints	Marital/parent/child	Bipolar/Mood Swings

Other:____

MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT INFORMATION:

Have you used Alcohol ________ Yes _______ No Nicotine ________ Yes _______ No

Drugs ________ Yes _______ No Caffeine ________ Yes _______ No

Have you had any previous outpatient treatment for emotional or mental health problems or substance abuse? ________ Yes _______ No

If yes, please list previous providers and dates of service:

Provider	Dates of Service

Have you ever been hospitalized for mental health reasons? ________ Yes _______ No

If yes, please list previous providers and dates of service:

Hospital	Date Entered	Date Discharged	Was it Helpful?

MEDICAL TREATMENT INFORMATION:

It may be necessary to sign a release of information for previous providers in order to request any information they have gathered about you. This would be better to serve you.

Primary Care Physician (PCP): ____ Release Signed ☐

Psychiatrist: ____ Release Signed ☐

List any Allergies or Sensitivities: ____

List any Physical Injuries: ____

____

List any Hospitalizations/Surgeries:

Hospital	Procedure	Date

Select Any Disabilities:

Mental Retardation

Physically (muscular/skeletal problem)

Physically (other problem)

Visually Impaired

Other ________________________________

Hearing Impaired

Speech Impaired

Brain Damage/Injury

None Known

List any Diagnosed Diseases: ____

____

List or provide a copy of Prescribed/Alternative Medications:

Medication	**Prescribed By**	**Dosage**	**Frequency**	**Start Date**