New Client Information Form

46 South Chestnut Street
Boyertown, PA 19512

Client Name:			☐**Male** ☐**Female**
Date of Birth:		**Social Security Number:**	
Address:			
Phone:		**Alt. Phone:**	

Parent/Guardian information**:**		**If client is an adult, skip this section and please check here ☐**	
Parent 1:		**Relationship:**	
Preferred Phone:		**Alt. Phone:**	
Home Address:			
Social Security Number:		**Email:**	
Parent 2:		**Relationship:**	
Preferred Phone:		**Alt. Phone:**	
Home Address:			
Social Security Number:		**Email:**	
Legal Custody: ☐Sole ☐Shared		**If Shared, list all with legal custody:**	
How is Physical Custody handled:			

Emergency contact:			
Name:		**Relationship:**	
Preferred Phone:		**Email:**	

Relationship Information:			
Status:	☐Single ☐ Married ☐Divorced ☐Widowed ☐In a relationship ☐Living together		
Do you share custody of any minor children with anyone?		☐Yes ☐No	
Is there a court order?	☐Yes ☐No	**Is there a pending custody case?**	☐Yes ☐No
Names and ages of your children:			
Who lives in your home with you?			

Car Information:			
Make:		**Model:**	
Year:		**Plate Number:**	

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Language Spoken at Home:
☐English
☐Spanish
☐Other:

Religion:
☐Protestant
☐Catholic
☐Jewish
☐Atheist/Agnostic
☐Other:

Veteran Status:
☐US Veteran
☐Combat Veteran
☐Never Served
Branch:

Education:						
1	2	3	4	5	6	7
8	9	10	11	12	☐GED	
☐Some College			☐Associates Degree			
☐Bachelor's Degree			☐Master's Degree			

Race:
☐Caucasian
☐African American
☐Hispanic
☐Native American
☐Asian/Pacific Islander
☐Prefer Not to Answer
☐Other:

Do You Receive Government Benefits:
☐Food Stamps
☐Social Security
☐Cash Assistance
☐Medical Assistance/Medicare
☐Other:

Employment Information:			
Status:	☐Employed Full Time ☐Employed Part Time ☐Unemployed ☐Retired ☐In School		
Name of Employer:			
Address:		**Phone:**	

History of Past Treatment/Services/Legal Issues:
☐Outpatient Mental Health ☐Outpatient Substance Abuse ☐Partial Hospitalization ☐Inpatient
☐Psychiatric Medication ☐Drug/Alcohol Rehab ☐Custody Evaluation ☐Incarceration/Arrest
☐Children and Youth Involvement ☐Probation/Parole ☐Family Based ☐Wraparound/BHRS
Please Explain:

Do you want us to contact anyone about your past treatment?	☐Yes ☐No
Are you currently receiving treatment/services for mental health?	☐Yes ☐No

Name of provider:			
Phone Number:		**Diagnosis:**	

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Health History:

Allergies: ☐No known allergies ☐ Allergic to: ☐Food ☐Medicine ☐Environment ☐ Other
Please list allergies and reaction:

Medications: ☐Client does not take daily medication ☐Client takes daily medication

Name of medication:	**Amount/Dose::**	**When is it taken:**	**How is it taken:**	**Reason Given:**

General Health History: Please circle any items that pertain and explain below.

Hospitalization	Surgery	Chronic Illness	Recent Injury

Please explain any circled items or other relevant information here:

Health Care Provider:

Primary Care Doctor:		Phone:	
Address:		Fax	

Medical Insurance Information: (please provide a copy of your insurance card with this form)

Insurance Company:		**Policy Number:**	
Subscriber:		**Insurance Phone:**	

Please explain why you are seeking services:

What type of service are you requesting:

☐Individual Therapy ☐Co-Parent Counseling ☐Reunification Therapy ☐Therapeutic Visitation
☐Family Therapy ☐Supervised Visitation – On site ☐Supervised Visitation – Off Site ☐Monitored Exchange

Signature of Client: (if over age 14)			
Relationship to Client (if client is minor)		**Date:**	

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As required by the Health Information Portability and Accountability Act of 1996 (HIPPA) you have a right to request that communication concerning your personal health information be made through confidential means.

I, _____, (Client Name), Date of Birth, _____, request the use of the following confidential channels for the communication of information related to my personal health, reminder appointments, treatment or payments for treatment. This request replaces any prior request for confidential communications I may have made.

☐**Primary**
I may be contacted at my **home phone** number: _____ ☐Yes ☐No

A message may be left on my answering machine: ☐Yes ☐No

☐**Primary**
I may be contacted at my **cell phone** number: _____ ☐Yes ☐No

A message may be left on my answering machine: ☐Yes ☐No

☐**Primary**
I may be contacted at my **work phone** number: _____ ☐Yes ☐No

A message may be left on my answering machine: ☐Yes ☐No

☐**Primary**
I may be contacted via **email** at: _____ ☐Yes ☐No

A message may be left on my answering machine: ☐Yes ☐No

If you would like to have information released to someone other than yourself, please complete the following and specify relationship:

Name:			☐Yes ☐No
Relationship:		**Phone:**	

Name:			☐Yes ☐No
Relationship:		**Phone:**	

Signature of Client: (if over age 14)			
Relationship to Client (if client is minor)		**Date:**	