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CLIENT INFORMATION SHEET

THIS IS CONFIDENTIAL CLIENT INFORMATION. PLEASE SEE CALIFORNIA WELFARE AND INSTITUTION CODE 5328

CLIENT DATA			
Last Name:	First Name:	Middle Name:	
Birth Name (if different from above):			
Social Security Number:		Mother's Maiden Name:	
Gender: <input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth:	Age:
Ethnicity:	If Hispanic, please indicate origin:		
Highest Education Level:		Marital Status:	
Living Arrangement (e.g., lives at home with parents, alone, spouse, etc.):			
Employer:			
CLIENT CONTACT INFORMATION			
Home Address:			
City:	State:	Zip Code:	E-mail address:
Telephone Nos: Home:		Cell:	Work (plus extension):
We value your confidentiality. However, there may be occasions when we need to contact you, e.g., to confirm an appointment. If we need to contact you by telephone, please indicate your preferred contact: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work			
EMERGENCY CONTACT INFORMATION			
Emergency Contact 1: Name:			
Address:			
Relationship:		Telephone No:	
Emergency Contact 2: Name:			
Address:			
Relationship:		Telephone No:	
PRIOR MENTAL HEALTH SERVICES RECEIVED			
Have you received prior mental health services? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If so, name of provider:		Telephone No.:	
Date of services (from, to):			
Medications (name and dosage):	Prescribed for:	Currently taking?	
_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No