CLIENT INFORMATION FORM
Area Mental Health Center

CLIENT #___________________

LAST NAME:

FIRST NAME:

MIDDLE NAME OR INITIAL:

MAIDEN NAME:

OTHER NAMES:

MAILING ADDRESS:

STREET ADDRESS:

CITY: STATE: ZIP:

HOME PHONE NUMBER: (____)_____-____________

WORK PHONE NUMBER: (____)_____-____________

MESSAGE PHONE NUMBER: (____)_____-____________

SPOUSE'S NAME:

PARENT OR GUARDIAN'S NAME:

PARENT OR GUARDIAN'S PHONE # (____)____-__________

Employment Status: *(Check One):*

- ☐ Full-Time
- ☐ Disabled
- ☐ Part-Time
- ☐ Retired
- ☐ Temporary
- ☐ Unemployed
- ☐ Independent Contractor
- ☐ Not in Labor Force

Employer:

Job Title:

Family Physician:

Pharmacy:

Medication Allergies:

Prior (last) Hospitalization:

- ☐ None
- ☐ State Mental Health Hospital
- ☐ Private Psychiatric Hospital
- ☐ Crisis Stabilization
- ☐ General Hospital Psychiatric Ward
- ☐ Inpatient Substance Abuse (excluding detox)
- ☐ Residential mental health treatment within State Correctional facility

Have you ever been in treatment with our Center?
(This includes the offices of Garden City, Dodge City, Scott City & Ulysses)

☐ Yes ☐ No

Please Indicate Location of Center:_______________________________

Please list any other mental health treatment:

DATE_________________

SOCIAL SECURITY NUMBER:

DOB: ____/____/____ GENDER: ☐ Male ☐ Female

Marital Status: *(Check One):* ☐ Married ☐ Divorced ☐ Legally Separated ☐ Single ☐ Widowed

Are you a Veteran: ☐Yes ☐No

ETHNICITY: *(Check appropriate box(es)*

- ☐ Asian
- ☐ White
- ☐ American Indian
- ☐ Other
- ☐ Hispanic or Latino
- ☐ More than one race reported
- ☐ Black or African American (not of Hispanic origin)
- ☐ Native Hawaiian or other Pacific Islander

Primary Language: _____________________________________

Secondary Language: __________________________________

Highest Level of Education Completed:

- ☐ High School Diploma
- ☐ GED
- ☐ 1 Year College
- ☐ 2 Years College (A.A.)
- ☐ 3 Years College
- ☐ 4 Years College (no degree)
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Gradwork(no degree)
- ☐ Doctorate Degree
- ☐ Vocational Training
- ☐ No Formal Education

If Currently a Student please answer the following:

Name of School:____

Current Grade:___________________

Name of Teacher(s):____________________________________

IMPAIRMENTS - Check all that apply

- ☐ Allergies
- ☐ Head injury
- ☐ Alzheimer's Disease
- ☐ Heart problems
- ☐ Anemia
- ☐ Hepatitis
- ☐ Asthma
- ☐ High blood pressure
- ☐ Blood clots
- ☐ HIV/AIDS
- ☐ Cancer
- ☐ Irritable Bowel Syndrome
- ☐ Chronic pain
- ☐ Korsakoff's Syndrome
- ☐ Cirrhosis
- ☐ Leukemia
- ☐ Constipation
- ☐ M.S.
- ☐ Crohn's Disease
- ☐ Menopause
- ☐ Diabetes
- ☐ Mental Retardation
- ☐ Diarrhea
- ☐ Eating Disorders
- ☐ Not Applicable
- ☐ Emphysema
- ☐ Overweight
- ☐ Parkinson's Disease
- ☐ Polio
- ☐ Pregnancy
- ☐ Seizure Disorder
- ☐ Sleep Disorder
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Underweight
- ☐ Urinary tract infection
- ☐ Fibromyalgia
- ☐ Arthritis
- ☐ Immune system suppression
- ☐ Blindness or severe visual impairment
- ☐ Deafness or severe hearing loss
- ☐ Developmental Disability
- ☐ Non-ambulation or major difficulties in ambulation
- ☐ Organically based problem in expressive communication
- ☐ Other chronic health condition requiring on-going care (list)