Patient Information

Date:

Patient's Name:
Last First

☐ Male ☐ Female

Current Address:

City: State: Zip Code:

Phone Number: Alternate Number:

Responsible Party: Relationship:

Referral Source

Type of Referral Source: ☐ Self ☐ POA ☐ RN, LMSW ☐ PCP *(name)*

☐ Other *(specify)* :

Contact Person: Email:

Phone Number: Fax Number:

Financial and Insurance Information

Primary Insurance: ☐ Medicare ☐ Medicaid ☐ Private Pay ☐ Private Insurance ☐ Other:

Group Number: ID or Policy Number:

DOB: Social Security Number:

Symptoms and Behaviors

☐ Anxiety, irritability, or restlessness	☐ Argumentative or Uncooperative	☐ Phobias
☐ Depression	☐ Poor adjustment to a medical condition	☐ Bi-polar
☐ Substance Abuse	☐ Emotional Outbursts	☐ Impulsive
☐ Sleep problems or disorders	☐ Exacerbation of health problems	☐ Decline in functioning
☐ Hallucinations	☐ Personality disorder	☐ Inappropriate sexual behavior
☐ Aggressive or disruptive behavior	☐ Schizophrenia	☐ Self abuse or mutilation
☐ Social isolation or withdrawal	☐ Danger to self or others	☐ Suicidal Ideation
☐ Poor appetite or significant weight fluctuation	☐ Non compliant with medical or nursing care	☐ Other:

Chronic Condition: ☐ Oncology ☐ Multiple Sclerosis ☐ Diabetes ☐ Muscular Dystrophy ☐ Other

Additional Information

How long has the patient/client had services with you?

Do you have any safety concerns for the client?

Is there any potential for violence or harm befalling anyone in the home?

Are there animals that pose a problem for a visitor in the home?

Does the client or someone in the home smoke or abuse alcohol or street drugs?

What are the names and contact numbers of other support services in this home?