

PATIENT INFORMATION

New client Readmission (date of last contact): ___ / ___ / ___

Name: (Last) _____ (First) _____ (MI) _____

DOB: ___ / ___ / ___ Gender: _____ Race: _____ Ethnicity: _____

Address: _____ Phone: (____) _____

County: _____ Insurance: _____

Prior Placement History: _____

Diagnosis: _____

Mental Health Service Providers: _____

Medications: _____

Adopted: Yes No LGBTQ+: Yes No Employed (only if 15 years or older): Yes No

System Involvement: Behavioral Health CPS Youth Services Juvenile Probation
 Juvenile Justice Special Education

Living Situation: Lives with Parent/Guardian Lives with Friend/Relative PRTF
 Shelter Acute Hospital

PARENT/GUARDIAN INFORMATION

Relationship: _____

Name: (Last) _____ (First) _____ (MI) _____

Address: _____ Phone: (____) _____

History of Drug/Alcohol Problems: Yes No Unsure Current Drug/Alcohol Problems: Yes No Unsure

REFERRAL INFORMATION

Referred by: _____ Phone: (____) _____

Reason for Referral: _____

Referring Service(s): Self-Awareness & Self-Care Substance Use & Abuse Psychosis Peer Recovery
 Nurturing Parenting Quick Response Team (QRT-Harrison Co.) SMART
 Tobacco/Vaping Treatment Hepatitis B Education & Referral Suicide Prevention
 Medicaid (Access Referral) Outreach & Community Engagement

Received by: _____ Date: ___ / ___ / ___ Time: _____ Reference #: _____