

TRI-COUNTY MENTAL HEALTH SERVICES, INC.

The following is needed to provide services. We ask that you fill out this form as completely as possible.

CLIENT INFORMATION:

SSN# _____

Last Name: _____ First Name: _____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ County: _____

Sex: M F Transgender Age: _____ D.O.B.: ____ / ____ / ____ Highest Educational Level Achieved: _____

Race: White African Am. Asian Hispanic Native Am. Pacific Islander Other: _____

If Hispanic, please check one: Mexican Cuban Puerto Rican Other _____

Employment Status: (check one) Full Time Part Time Disabled Retired Unemployed Homemaker

Occupation: _____

Marital Status: (check one) 1. Never married 2. Married 3. Widowed 4. Divorced 5. Separated

Hearing Status: Normal Impaired Deaf Veteran: Yes No Primary Language: _____

FINANCIALLY RESPONSIBLE PARTY:

Last Name: _____ First Name: _____ Relationship to client: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Daytime Phone: _____ SSN: _____

Household Weekly Income: \$ _____ Number of Dependents: _____ Number in Household: _____

Do you have ? Medicare #: _____ Medicaid #: _____

Other Medical Insurance Policy #: _____ Company Name: _____ Phone #: _____

COMPLETE FOR CHILDREN ONLY:

Mother's Name: _____

Father's Name: _____

Step-Mother's Name: _____

Step-Father's Name: _____

Foster Mother's Name: _____

Foster Father's Name: _____

CUSTODY OF CHILD:

Joint Custody of Parents-- Names of joint custodians: _____

Sole Custody of Parent – Name of custodian: _____

State Custody ** -- which Agency/Contact person: _____

** Copy of current court order showing custody is required.

Other – Please describe other legal authority and furnish documentation

Is there a LEGAL GUARDIAN? Yes No Copy of letters of guardianship provided to Tri-County: Yes No

Guardian's Last Name: _____ Guardian's First Name: _____ Relationship to Client: _____

Home Phone: _____ Daytime Phone: _____ Address: _____

EMERGENCY CONTACT: _____ Home #: _____ Work #: _____

Address: _____ Rel. to Client: _____

VERIFICATION:

I verify that the above information is accurate.

Client Signature: _____ Date: _____

Parent/Guardian: _____

For Office Use Only

Staff: _____ New Readmit Update Admit Date: _____ MR #: _____

CLIENT INFORMATION SHEET

Rev. 10/21/15

FORMS/Intake/Client Info Sheet