

ADULT INFORMATION FORM

Name: Last _____ First _____ Middle Initial _____ Maiden _____

Address/City/St/Zip/Co: _____

Home Number () -	May we leave a message at this number?	YES/NO
Cell Number () -	May we leave a message at this number?	YES/NO
Business Number () -	May we leave a message at this number?	YES/NO

SSN: _____ Gender: Male Female DOB: _____ Age _____

Marital Status (Please Circle One): Single Married Divorced Separated Widowed

Are you currently, or have you ever received services? ☐ Yes ☐ No If yes, where? _____

Referred by (Primary): _____ (Secondary): _____

If referred by the court/criminal justice system what county where the legal proceedings held? _____

Number in Household: _____

Source of Income:

☐ Employment ☐ SSI ☐ SSDI ☐ Food Stamps ☐ TANF ☐ Other: _____

Insurance:

☐ Private ☐ Medicaid ☐ Medicare ☐ Private Pay ☐ Other: _____ ID# _____

Race (check all that apply): ☐ American Indian ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander

☐ White ☐ Other ☐ Hispanic/Latino

Spiritual Orientation: ☐ Christian ☐ Jewish ☐ Muslim ☐ Other ☐ None ☐ Prefer not to comment

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Other ☐ Prefer Not to Comment

Emergency Contact Name: _____ Relationship (Rel): _____

Phone #: _____ Address: _____

Employer: _____ Name of Insurance: _____

Is there someone you would like to come with you and participate in your services? ☐ Yes ☐ No ☐ N/A

Preferred Language: _____ Other Languages Spoken: _____

Will you need any special help or equipment? ☐ Yes ☐ No If yes, please describe: _____

Physician: _____ Phone Number: _____

Preferred Hospital: _____

Client Signature: _____ Date: _____

