Southfield Mental Health Associates, P.C.

Date Contacted__________

**NEW CLIENT INFORMATION**

Date Offered____________

Name________________________________________ Home Phone #_______________
Address______________________________________ Work Phone #_______________
City__________________ State_____ Zip________ Pager Phone #______________
Birth Date_______________ Age ________ Driv Lic ____________________________
Race (or ethnic grp)____________________ Education Completed ________________
Employer/address_____________________________________ Approx inc ____________
Referred By (name & address)___________________________ Relig ________________

Others in Home (Name) (Relationship) (Age) (Employer or School)

______________________ ________________ ______ ___________________

______________________ ________________ ______ ___________________

______________________ ________________ ______ ___________________

Nearest Relatives (Name) (Relationship) (Address) (Phone #)

____________________ __________ _____________________ ______________

Medical History (Major Illnesses and Surgeries, Hospitalizations, Previous Therapy)______________

_____________________________________________________________________________

_____________________________________________________________________________

(Children & Adolescents) Developmental history. Detail significant findings in speech, hearing, vision, motor developm & functioning,immunizations, intellectual functioning, learning ability, peer relations, environmental surroundings, prenatal exposure to alcohol, tobacco, or other drugs, and direct use of alcohol, tobacco, or other drugs. ___ All developmental milestones & functions within normal range. Or Signif finding in above (cont on reverse) ________________________________________

_____________________________________________________________________________

Current Medications Dose/Frequency Prescribing Physician & Phone

_______________________ _________________ _________________________

_______________________ _________________ _________________________

Other Medications During Previous Six Months (include dose and frequency): __________________

_____________________________________________________________________________

History of Allergies/Adverse Reactions/Ineffective Meds ________________________________
Notify in Case of Emergency___________________________________ Phone________________
Family Physician & Phone_______________________________________________________
Primary Ins ____________________ Eff Date ________Name, relshp of Insured _______________
Group_____________ Plan/Service Code___________ Contract/ID #___________________
Deductible_________ Copay _____________ Annual Max ($ or # of Sessions)______________
Ins. Co. Billing Address & Phone #__________________________________________________

Secondary Ins___________________ Eff Date _______Name,relshp of insured ________________
Group______________ Plan/Service Code__________ Contract/ID #____________________
Deductible__________ Copay ____________ Annual Max ($ or # of Sessions)______________
Ins. Co. Billing Address & Phone #__________________________________________________

Evaluator/Therapist___________________________ Fee_________________ Dx__________