



SCREENING INFORMATION

Please Print Clearly

THIS SHEET MUST BE FILLED IN COMPLETELY

Date _____ Last 4 digits of social security # _____
Client's First Name _____ Last Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Telephone (Home) _____ (Work) _____
Birthdate ____/____/____ Age _____ Gender ___F___M___ Race _____
Name of Spouse/Guardian _____ Phone _____
Address _____ City _____ State _____ Zip _____
Person Responsible for Payment _____ Soc. Sec. # _____
Signature of Person Responsible for Payment **X** _____

(Must be signed for services to begin)

Emergency Information

In case of emergency, contact:

Name (1) _____ Relationship _____ Phone _____ Work _____
Address _____ City _____ State _____ Zip _____

Name (2) _____ Relationship _____ Phone _____ Work _____
Address _____ City _____ State _____ Zip _____

Physician _____ Phone _____
Address _____ City _____ State _____ Zip _____

Psychiatrist _____ Phone _____
Address _____ City _____ State _____ Zip _____

Other Physicians _____ Phone _____

Current Medications _____

Allergies _____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place _____ Phone _____ Hrs _____

Spouse: Place _____ Phone _____ Hrs _____

Referral Source

How did you hear of Blossom Behavioral Health (or from whom)? _____

Relationship to referral source _____