PATIENT SCREENING

DATE: ____________________ PHONE(s): ____________________ or ____________________

NAME: ________________________________ GUARDIAN (If applicable): ______________________

DOB: ____________________ AGE: _________________ SSN: ________________________________

ADDRESS: ____
____

INSURANCE(S) ____
____

CURRENT PHYSICIAN: ____

REASON FOR LEAVING ____
____
____

WHERE DID YOU HEAR ABOUT US? ____
DO WE SEE ANY FRIENDS/FAMILY MEMBERS?: YES / NO –
If “yes” then who? ___________________________

MEDICAL PROBLEMS ____
____
____

CURRENT SYMPTOMS ____
____
____

MEDICATIONS ____
____
____

Info Taken By: ______
DECISION: ***YES / NO***
Notes / Comments ____
____
____