Wagner Behavioral Health Services, LLC

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Client Demographic Information Form

Today's date: _____

A. Identification

Client's name: _____ Date of birth: _____ Age: _____
First Middle Initial Last *00/00/0000*

S.S # _____ Nicknames or aliases: _____ County: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: (____)_____ Cell phone: _____

e-mail: _____

*(Notice: E-mail communications are **not private** and can be easily accessed by unauthorized people, and therefore can compromise the privacy and confidentiality of such communication. Please do not use e-mails for emergencies. E-mails may not always be checked regularly.)*

Calls or e-mail will be discreet, but please indicate any restrictions: _____

_____

B. Referral: Who gave you my name to call?

Name: _____ Phone: (____)_____

Address: _____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No

How did this person explain how I might be of help to you? _____

_____

C. Religious and racial/ethnic identification

Current religious denomination/affiliation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist
❑ Hindu ❑Other (specify): _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting are you involved with? _____

Ethnicity/national origin: _____ Race: _____ or

other similar way you identify yourself and consider important: _____

D. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: (____)_____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

(cont'd)

E. Current Medical Conditions:

❑ Asthma/COPD ❑ Cancer ❑ Cardiovascular Problem ❑ Chronic Pain ❑ Dementia
❑ Diabetes ❑ Obesity ❑ Other _____ ❑ None

List all medications including non-prescription currently taking: _____

_____

F. Allergies (Medical or Other): _____

_____

G. Your current employer

Employer: _____ Address: _____

Work phone: (____)_____ or other means of communication _____

Calls will be discreet, but please indicate any restrictions: _____

H. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: (____)_____ Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you: _____

I. Your education and training

Dates		Schools	Special classes?	Adjustment to School	Did you graduate?
From	To				

J. Employment and military experiences *(if you need more space, continue on the back of this form)*

Dates		Name of employers	Job title or duties	Reason for leaving
From	To			

K. Family-of-origin history *(if you need more space, continue on the back of this form)*

Relative Name	Current age (or age at death)	Illnesses (or cause of death, if deceased	Education	Occupation
Father				
Mother				
Brothers				
Sisters				
Stepparents				
Grandparents				
Uncles/aunts				
Others				

(Cont'd)

L. Marital/relationship history *(if you need more space, continue on the back of this form)*

	Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Has spouse remarried?
First					
Second					
Third					

M. Significant non-marital relationships

	Name of other person	Person's age	Your age	Your age	Reasons for ending
Second					
Third					
Current					

N. Children Indicate those from a previous marriage or relationship with "P" in the last column.

Name	Current age	Sex	School	Grade	Adjustment problems?	P?

O. Is there any other information you think we should know?

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.