

Adult Pre-admission Information Sheet

Admit Date: _____ Transportation: _____

Original Contact Date (OCD): _____ Assessment Received: _____

Name: _____ DOB: _____

Address: _____ City & State: _____ Zip: _____

Telephone #: _____ Soc Sec #: _____

Enrollment #: _____ Reservation: _____

Emergency Contact (Name & relationship): _____ ph#: _____

Referent: _____ Telephone #: _____

Referring Agency: _____ Address: _____

Funding (# of days in treatment): _____ Check one: _____ Consolidated Funds through: _____
Insurance: Company: _____
ID #: _____ Group #: _____
Deductible: _____ CoPay: _____

Medical Condition (s): _____

If client is female, is she pregnant? Circle Yes or No If Yes, additional information may be requested.

Prescription Medications: _____

Physician: _____ Telephone #: _____

Address: _____ City & State: _____ Zip: _____

Has the client ever been diagnosed with a Mental Health Disorder? Circle Yes or No If Yes, please specify Mental Health Issues/Diagnosis/Meds: _____

Has the client ever been charged with a sexual assault?: Yes ___ No ___ (if yes, explain on the back)

Legal Issues: _____

Probation Officer's Name: _____ ph#: _____

Address: _____ City & State: _____ Zip: _____