

**DEMOGRAPHIC INFORMATION**

Intake Date: \_\_\_\_\_ DOB: \_\_\_\_\_

Soc. Sec. #: \_\_\_\_\_ Male: \_\_\_ Female: \_\_\_\_\_

Age: \_\_\_\_\_ Race: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work#: \_\_\_\_\_

**Emergency Contact Person:** \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_

**Probation Officer Name** \_\_\_\_\_ Adult \_\_\_ Juvenile \_\_\_\_\_

Phone \_\_\_\_\_ City/County \_\_\_\_\_

**FSC is responsible for reporting any communicable disease(s) to the Department of Health and Rehabilitative Services/ Health Dept. The agency is also mandated to report any child abuse to DCFS. HIV/AIDS shall be discussed in a confidential setting with the consumer's counselor.**

**Client Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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**OFFICE USE ONLY**

Purpose of Visit:

- |                      |                    |               |
|----------------------|--------------------|---------------|
| ___ Mental Health    | ___ Med Checks     | ___ Drug test |
| ___ Substance Abuse  | ___ M.D. Visit     | ___ Insurance |
| ___ Psychiatric Eval | ___ Family Therapy | ___ Self Pay  |
| ___ Suboxone         |                    |               |

**Patient Diagnosis:** \_\_\_\_\_

Axis I

\_\_\_\_\_

Axis II

**Provider's Name** \_\_\_\_\_

**Discharge Date:** \_\_\_\_\_