SELFAWARE 101

Please provide the following information and answer the questions below. Please note that the information you provide here is protected as confidential information.

NAME: _____
Last First Middle Initial

ADDRESS: _____
Street and Number City State Zip Code

(if minor, please complete)
NAME OF PARENT(s)/GUARDIAN(s): _____
Last First

CONTACT INFORMATION:

HOME PHONE: _____ *May I leave a message?* ☐ *yes* ☐ *no*

CELL PHONE: _____ *May I leave a message?* ☐ *yes* ☐ *no*

WORK PHONE: _____ *May I leave a message?* ☐ *yes* ☐ *no*

E-MAIL ADDRESS: _____
Please note that email correspondence is not considered to be a confidential means of communication.

DATE OF BIRTH: 05/03/2017 **AGE:** _____ **GENDER:** ☐ Female ☐ Male

MARITAL STATUS:
☐ Never Married ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed

PLEASE LIST ANY CHILDREN AND THEIR AGE (S):

_____

OTHER HEALTH/SERVICE PROVIDERS *(e.g. Primary Care Physician, Psychiatrist, etc.)***:**

NAME: _____ PROVIDER ROLE: _____
PHONE: _____

NAME: _____ PROVIDER ROLE: _____
PHONE: _____

EMERGENCY CONTACT (S):

NAME: _____ RELATIONSHIP to PATIENT: _____

ADDRESS: _____ PHONE: _____

REFERRED BY: _____ **PHONE:** _____