Crosspointe Family Services--Patient Demographics
Please fill out front and back of Form.

Patient Information

Last Name: _____ First: _____ Middle: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Soc. Sec. #: _____ Date of Birth: _____ Age: _____ Birth Sex: **M F**

Language: _____ Gender Identity: _____ Pronoun Set: _____

E-mail:

Custodian/Guardian Information FOR YOUTH 18 or Younger

Who does the child live with? Name: _____

Address: _____ Phone: _____

Does this person have the legal authority to consent for treatment? Yes No

If Yes, circle one: Biological/Adoptive Parent Legal Guardian Foster Parent IDHW Caseworker

If No, who has this authority? Name _____Phone:_____

Address: _____ City: _____ State: _____ Zip: _____

****We are unable to see a youth client without the consent of the legal parent/guardian/custodian.**

Additional Demographics

Primary Health Care Provider: _____ Marital Status: _____

Address: _____ Spouse:

Phone: **Race:** **Ethnicity:**

Referring Source: _____ 1 1 Hispanic

Reason for seeking treatment/What you hope to gain/What 2 Prefer not to answer 2 Non-Hispanic

would you like to be different: _____

Medical/Mental Health History

Current Medications: _____

Allergies: _____

Medical/Mental Health History (Current or past): _____

Family Mental Health History: _____

Mental Health Symptoms

Have you had any of the following: (Please circle)

Anxiety: Yes No
Depression: Yes No
Mania: Yes No
Psychosis: Yes No
Abuse: Yes No
Trauma: Yes No

Sleeping: Yes No
Eating Habits: Yes No
Attention & Impulse Control: Yes No
Anger & Aggression: Yes No
Developmental Deficit: Yes No
Other Emotional/Mental Health Considerations: Yes No
Describe: _____

Alcohol Use: Yes No _____
Drug Use: Yes No _____

Insurance

Insurance: _____ Relationship to Patient: _____
Member ID: _____ Group ID: _____
Subscriber: _____ Subscriber DOB: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Cell Phone: _____

Emergency Information

IN CASE OF EMERGENCY CONTACT (Person NOT LIVING with patient).

Contact Name: _____ Relationship to Patient: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Cell Phone: _____

I verify that all information above is true, to the best of my knowledge.

Patient Signature: _____ **Date:** _____

Guardian Signature: _____ **Date:** _____