**Client Name:**   **Date:**

Date of Birth: / / Age: Client SSN:

🞎 Male 🞎 Female

**Mailing Address:**  P. O. Box:

City: State: Zip:

Physical Address (if different from above):

Is it OK to send mail? 🞎 Yes 🞎 No

Home Phone: OK to call? 🞎 Yes 🞎 No

Cell / Track Phone: OK to call? 🞎 Yes 🞎 No

Work Phone: OK to call? 🞎 Yes 🞎 No

**Referral Source (check one) Payment Source (check one)**

🞎 Court-Ordered 🞎 Primary Care Physician 🞎 Insurance / HMO

🞎 CYFD 🞎 School 🞎 Medicaid / Medicare

🞎 Family / Friends 🞎 Self-Referral 🞎 Medicaid Only

🞎 EAP Program 🞎 Sunrise / Hospital 🞎 Medicare Only

🞎 Probation/Parole 🞎 Pastor / Church 🞎 ISD / State-Covered Insurance

🞎 Previous Care Provider 🞎 Other

**Have you received services at Ellington Counseling Services before?** 🞎 Yes 🞎 No

If yes, approximate date of last services:

Under what name?

**Have you received mental health and/or substance abuse services before?** 🞎 Yes 🞎 No

If Yes, where?

**Race / Ethnicity / Tribe:**

**City of Birth:**

**Marital Status:**

🞎 Single 🞎 Married 🞎 Divorced 🞎 Separated 🞎 Widowed 🞎 Living as Married 🞎 Other (please specify)

**Name at Birth:**

**Employment Status:**

🞎 Full-time 🞎 Part-time 🞎 Homemaker 🞎 Unemployed 🞎 Disabled 🞎 Student

Employer: Position:

School: Grade: Last Grade Completed:

**Living Arrangements:**

🞎Private Residence or Apt. / Alone 🞎 Private Residence w / Family

🞎 Private Residence w / Roommate 🞎 Dorm 🞎 Shelter Care

🞎 Supervised Care 🞎 Homeless 🞎 Parent / Child 🞎 Guardian

Are You a Veteran?🞎 Yes 🞎 No Are You a U.S. Citizen? 🞎 Yes 🞎 No

**Primary Language:**

🞎 English only 🞎 Spanish only 🞎 English and Spanish 🞎 Other

**In the last 30 days, have you been in any of the following?:**

🞎 Jail / Prison 🞎 Inpatient Alcohol or Drug Treatment 🞎 Inpatient Medical Treatment

🞎 Inpatient Psychiatric Treatment 🞎 None 🞎 Homeless Shelter

**Emergency Contact Information:**

Responsible Person: Relationship:

Physical Address: Phone:

City: State: Zip:

Best Way to Contact:

**Legal Information:**

Guardianship: CYFD Custody Status:

Responsible Person: Relationship:

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

**Why Have You Come to Ellington Counseling Services?**

Present Concerns and Problems. **Completion of this section is extremely important.**

1.
2.
3.
4.
5.
6.

**Current Medications:**

1. Name: Dosage: Frequency:

2. Name: Dosage: Frequency:

3. Name: Dosage: Frequency:

4. Name: Dosage: Frequency:

5. Name: Dosage: Frequency:

6. Name: Dosage: Frequency:

Who prescribed these medications:

**Past Psychiatric Medications:**

1. Name: Dosage: Frequency:

2. Name: Dosage: Frequency:

3. Name: Dosage: Frequency:

4. Name: Dosage: Frequency:

5. Name: Dosage: Frequency:

6. Name: Dosage: Frequency:

Who prescribed these medications:

**Allergies to Medications:**

1. Name:

2. Name:

3. Name:

4. Name:

**Past Mental Health Diagnoses:**

**Past Substance Abuse Diagnoses:**

Are you currently pregnant? 🞎 Yes 🞎 No

Do you have HIV? 🞎 Yes 🞎 No

Do you have Tuberculosis? 🞎 Yes 🞎 No

**ECSLLC Staff Use Only**

Date Comment