RIGHT VIEW
HEALTH SERVICES

Date: _____ Completed By: _____

Client Information:

Name: Last: _____ First: _____ M: _____ Title: ____
Current Address: _____ City: _____ State: ____ Zip :_____
Phone Number: (Home)_____ (Cell) :_____ Preference: _____
Email Address: _____ May we contact you by email? Y / N
Gender: _____ DOB: ___/___/____ Age: _____ Social Security Number: _____-_____-_____
Employer: _____ Occupation: _____
Emergency Contact Person: _____ Phone Number: _____
Relationship: _____

Do you have Medical Insurance? Y / N
Medicaid ID: _____ Medicare ID: _____
Insurance Name: _____

Do you Receive SSI/SSDI? Y / N
Are you Employed? Y / N
Do you receive Alimony? Y / N
Do you Receive SNAP? Y / N

Do you own a Nevada State I.D.? Y / N
Do you own a Social Security Card? Y / N
Do you own a Clarity Card? Y / N

Educational History:
Highest Level of Education Completed: _____
Did you attend College? Y / N Where? _____ Degree?: Y / N
Degree Earned: _____

Physical Health Information

Physical Health Diagnosis:

_____
_____
_____
_____
_____
_____

RIGHT VIEW
HEALTH SERVICES

Physical Health Hospitalization

Hospital **Reason for Stay** **Duration**

_____

_____

_____

_____

_____

_____

Primary Doctor

Name: _____

Location: _____

_____

Phone Number: _____

Fax: _____

Mental Health Information

Mental Health Diagnosis: In client's own words

Major Depressive Disorder	Post-Traumatic Stress Disorder (PTSD)	Dissociative Disorder
Generalized Anxiety Disorder	OCD	Eating Disorder:
Bi-Polar	Schizophrenia:	Personality Disorder
Panic Disorder	ADD/ ADHD	Other:
Other:	Other:	Other:

Mental Health Hospitalization

Hospital **Reason for Stay** **Duration**

_____

_____

_____

_____

_____

Mental Health Information

Current Therapist

Name: _____

Location: _____

_____

Phone Number: _____

Fax: _____

Previous Providers

(Case Managers, PSR, BST, Payee etc...)

Name: _____

Address: _____

Phone: _____

Fax: _____

RIGHT VIEW
HEALTH SERVICES

Name: _____
Address: _____
Phone: _____
Fax: _____

Substance Abuse:

Do you abuse Alcohol or Drugs? Y / N
If yes, for which substances? _____
Have you ever been treated for Alcohol/Drug Abuse? Y / N
If yes, for which substances? _____
Check Drugs Used:

Methamphetamine	**Cocaine**	**Opioids**
Heroin	**LSD or Hallucinogens**	**Pain killers (unprescribed)**
Methadone	**Alcohol**	**Ecstasy**
Other:	**Other:**	**Other:**

If yes, how long and when you last used:
_____

I declare that all the information stated above is true to the best of my knowledge.

_____ **_____**
Client Signature/Date **Interviewer Signature**