



Date of Birth:	Patient Last Name:	First Name:		MI:	Sex: M/F	
Primary Language: Race/Ethnicity: Referring Physician: Pediatrician: Pediatrician: Relationship to patient (circle one) Mother Father Other: Sex: M/F Street Address: City: State: Zip: State: Zip: Parent/Guardian 2 Information: Relationship to patient (circle one) Mother Father Other: Sex: M/F Street Address: Date of Birth: SS# Work Phone: Work Phone: Work Phone: Parent/Guardian 2 Information: Relationship to patient (circle one) Mother Father Other: Sex: M/F Street Address: City: State: Zip: State: Zip:	Date of Birth:/ SS	#: Cell Phone:	H	lome Phone:		
Referring Physician:	Street Address:	City:		State:	_ Zip:	
Parent/Guardian 1 Information: Relationship to patient (circle one) Mother Father Other:	Email:	Primary Language:	Race	e/Ethnicity:		
Parent/Guardian 1 Information: Relationship to patient (circle one) Mother Father Other:	Referring Physician:					
Parent/Guardian 1 Information: Relationship to patient (circle one) Mother Father Other:	Pediatrician:					
Last Name:			Mathan Fathan	Otherm		
Street Address: Date of Birth: SS#						
Email: Date of Birth: SS#						
Cell Phone: Home Phone: Work Phone:						
Parent/Guardian 2 Information: Relationship to patient (circle one) Mother Father Other:						
Last Name:First Name:MI:Sex: M/F Street Address:City:State:Zip: Email:Date of Birth:SS#	Cell Phone:	Home Phone:	Work Phone:			
Street Address:	Parent/Guardian 2 Information:	Relationship to patient (circle one)	Mother Father	Other:_		
Email: Date of Birth: SS#	Last Name:	First Name:	MI:	Sex: M/F		
Cell Phone:	Street Address:	City:		State:	_ Zip:	
Parents are: Married/ Single/ Divorced (please circle) *Note: If any special parental or custodial relationship (such as custody with one parent only, legal custody/guardians with no parent, etc.) is in please explain in the space below with your signature, printed name, and a phone number at which you can be contacted. Signature: Print Name: Phone: Emergency Contact Information: Contact Name: Relationship to Patient: Consent of File: Yes No Primary Insurance Information: Insurance Company Name: Name of Insured: Parent 1 Parent 2 Street Address: Group #: SS# of Insured: Secondary Insurance Information: Insurance Company Name: Name of Insured: Parent 1 Parent 2 Street Address: Group #: SS# of Insured: Secondary Insurance Information: Insurance Company Name: Name of Insured: Parent 1 Parent 2 Secondary Insurance Information: Insurance Company Name: Name of Insured: Parent 1 Parent 2 Street Address: Name of Insured: Parent 1 Parent 2 Street Address: Name of Insured: Parent 1 Parent 2 Street Address: Name of Insured: Parent 1 Parent 2	Email:	Date of Birth: S	S\$#			
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Emergency Contact Information: Contact Name: Relationship to Patient: Cell Phone: Home Phone: Consent of File: Yes No Primary Insurance Information: Insurance Company Name: Name of Insured: Parent 1 Parent 2 Street Address: City: State: Zip: ID #: Group #: SS# of Insured: Secondary Insurance Information: Insurance Company Name: Name of Insured: Parent 1 Parent 2 Street Address: City: State: Zip:	*Note: If any special parental or custodial relationship (such as custody with one parent only, legal custody/guardians with no parent, etc.) is in					
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Cell Phone:	Emergency Contact Information:					
Primary Insurance Information: Insurance Company Name:	Contact Name:	Relationship to Patient:		_		
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Insurance Company Name: Name of Insured: Parent 1 □ Parent 2 □ Street Address: City: State: Zip: ID #: Group #: SS# of Insured: Secondary Insurance Information: Insurance Company Name: Name of Insured: Parent 1 □ Parent 2 □ Street Address: City: State: Zip:	Primary Insurance Information:					
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Bridgeway Health Services provides quality recovery-oriented behavioral and mental health services and support to individuals in the community without regard to race, color, national origin, age, religion, philosophy, disability, sexual orientation, gender identification or gender expression. We strive to consistently provide an atmosphere of diversity, equity and inclusion within our organization and among the people we serve.

Health History

Height:	_ Weight:	
Caffeine Use: YES / NO	# Cups per day of Coffee, Tea, or	Soda?
Alcohol Use: YES / NO	# Drinks per Day, Week, or Month	n?
Tobacco Use: YES / NO	# Packs per Day?	
Smokeless Tobacco Use	? YES/NO	
	any medications? YES / NO (Prescribed on notice), dosage, how often?	•
	t or ongoing medical problems? YES / NO and duration?	
Previous Medical Hospit	talizations and/or Surgeries?:	
Prior Therapy/Counselin	ng?: YES / NO If yes, name of therapist, when	n and duration?:
Prior Psychiatric Hospita	alization? YES / NO If yes, where, where, dur	
Family History of Mental	Illiness? YES / NO If yes, who? Mother, Fath	ner, Sister, brother, Aunt, Uncle, Grandparents?
Current or Prior Substan	nce Use? Alcohol / Drugs / Both:	
Family History of Substa	ance/Alcohol Abuse?: YES / NO If yes, who?	?
Allergies to Medications	?:	_
Please explain why you	are here today:	
Parent/Guardian Signatu	ıre:	 _ Date: