

Amy J. Finn, Marriage and Family Therapy, LLC

SCREENING INFORMATION

Please Print Clearly **THIS SHEET MUST BE FILLED IN COMPLETELY** Readmit: Yes No

Date _____ Client's Social Security # _____ Case # _____

Client's First Name _____ Last Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____

Birthdate / ____ / ____ Age _____ Gender F M Race _____

Name of Spouse/Guardian _____ Phone _____

Address _____ City _____ State _____ Zip _____

Person Responsible for Payment _____ Soc. Sec. # _____

Signature of Person Responsible for Payment X _____ (Must be signed for services to begin)

Emergency Information

In case of emergency, contact:

Name (1) _____ Relationship _____ Phone _____ Work _____
Address _____ City _____ State _____ Zip _____

Name (2) _____ Relationship _____ Phone _____ Work _____
Address _____ City _____ State _____ Zip _____

Physician _____ Phone _____
Address _____ City _____ State _____ Zip _____

Psychiatrist _____ Phone _____
Address _____ City _____ State _____ Zip _____

Other Physicians _____ Phone _____

Current Medications _____

Allergies _____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place _____ Phone _____ Hrs _____

Spouse: Place _____ Phone _____ Hrs _____

Insurance Information

Primary Insurance _____ Secondary Insurance _____

Phone _____ Phone _____

Contract/ID# _____ Contract/ID# _____

Group/Acct# _____ Group/Acct# _____

Subscriber _____ Subscriber _____

Subscriber Date of Birth _____ Subscriber Date of Birth _____

Client's relationship to Subscriber _____ Client's relationship to Subscriber _____

Self Spouse Child Other _____ Self Spouse Child Other _____

Referral Source

How did you hear of our clinic (or from whom)? _____

Address _____ City _____ State _____ Zip _____

Phone _____ Relationship to referral source _____