Front Range Family Psychiatry LLC Client Information Form

Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ Zip Code: _____

Phone: _____ (Please circle) Home Cell Message

Alternate Phone: _____ (Please circle) Home Cell Business Message

Social Security Number: _____ Employer: _____

Occupation: _____

Spouse/Significant Other/Family Member/**EMERGENCY CONTACT NAME**: _____

Emergency Contact Cell Phone: _____ Work Phone: _____

Gender: ❑Female/Woman ❑Male/Man ❑ Non-binary ❑ Transgender ❑ Intersex ❑ Gender Non-Conforming
❑ Other _____ Pronoun preference: _____

Marital Status: ❑Single ❑Married ❑Divorced ❑Separated ❑ Other: _____

Military Service: ❑NONE ❑Army ❑Navy ❑Air Force ❑Marines ❑Coast Guard ❑Reserves
How were you referred to this practice: ❑Website ❑Facebook ❑Newspaper ❑School _____
❑Therapist_____ ❑Provider _____ ❑Friend _____ ❑ Other_____

Religious Affiliation: ❑Atheist ❑Baha'i ❑Baptist ❑Buddhism ❑Catholic ❑Christian ❑Confucianism ❑Druid
❑Hindu ❑Hutterite ❑Islamic ❑Jainism ❑Jewish ❑Latter Day Saints ❑Lutheran ❑Mennonite ❑Methodist
❑Protestant ❑Shinto ❑Sikhism ❑Taoism ❑Wiccan ❑Zoroastrianism ❑Native Culture _____
❑Other Not listed_____

INSURANCE INFORMATION:

Insurance Carrier: _____ Member ID/Policy # _____
Group # _____ Employer: _____
Insured Policyholder Name: ❑ Client listed above **OR**
Other Insured Name_____ Relationship to Client _____
Insured DOB: _____ Gender _____ Social Security Number: _____
Insured Policyholder Address ❑ Same as above **OR** _____
Employer if different from above: _____

Supplemental Insurance: ❑ None ❑ Yes _____
(List Insurance Name, Policy Number, Group Number)

I certify that I or my dependents have insurance coverage with the above listed company and assign directly to Front Range Family Psychiatry LLC all insurance benefits. I understand that I am financially responsible for all charges not paid by my insurance. I authorize the use of my signature on all insurance submissions.

Signature of Client: _____

MEDICAL AND MENTAL HEALTH HISTORY

Please indicate which conditions have been experienced by the following individuals by marking the appropriate boxes.

S = SELF **M = MOTHER** **F = FATHER**

S	M	F		S	M	F		S	M	F	
❑	❑	❑	Anemia	❑	❑	❑	Chest pain	❑	❑	❑	German measles
❑	❑	❑	Back pain	❑	❑	❑	Diabetes	❑	❑	❑	Reproductive disorder
❑	❑	❑	Cancer	❑	❑	❑	Epilepsy	❑	❑	❑	Depression
❑	❑	❑	Convulsions	❑	❑	❑	Heart trouble	❑	❑	❑	Anxiety
❑	❑	❑	Dislocated joints	❑	❑	❑	Kidney disorder	❑	❑	❑	Chicken Pox
❑	❑	❑	Headaches	❑	❑	❑	Multiple sclerosis	❑	❑	❑	Shingles
❑	❑	❑	High Blood Pressure	❑	❑	❑	Poor circulation	❑	❑	❑	Schizophrenia
❑	❑	❑	Menstrual Cramps (Females)	❑	❑	❑	Rheumatism	❑	❑	❑	Bowel control loss
❑	❑	❑	Neck pain	❑	❑	❑	Broken bones	❑	❑	❑	Muscular dystrophy
❑	❑	❑	Polio	❑	❑	❑	Asthma	❑	❑	❑	Numbness
❑	❑	❑	Rheumatic Fever	❑	❑	❑	Bone fracture	❑	❑	❑	Bipolar Disorder
❑	❑	❑	Cutting	❑	❑	❑	Concussion	❑	❑	❑	Hepatitis
❑	❑	❑	Serious Injury	❑	❑	❑	Traumatic Brain Injury	❑	❑	❑	Scarlet Fever
❑	❑	❑	Arthritis	❑	❑	❑	Indigestion	❑	❑	❑	Tuberculosis
❑	❑	❑	Bladder Trouble	❑	❑	❑	Lupus	❑	❑	❑	Fibromyalgia
				❑	❑	❑	Trauma History	❑	❑	❑	Suicide Attempts

Allergies:_____

SURGICAL HISTORY: Please list any surgeries and dates below:

_____

_____

PSYCHIATRIC HOSPITALIZATIONS: Please list any psychiatric hospitalizations below:

_____

Do you have access to Guns: ❑Yes ❑No How many hours of Sleep do you get on average per night? _____

CURRENT MEDICATIONS (INCLUDING VITAMINS) Please use back of form for more space.

Name of Medication	Dose (ex: 100 mg or one tablet)	How you take (Once a day, at bedtime)?	Is this a new or old medication for you?	Any negative side affects you notice?

Herbals/Over the counter (OTC) medications: _____
_____
_____

Edibles: _____

Please check all substances you have tried, used, or which you use on a regular basis:

Tried	Used in The past	Use Regularly	
❑	❑	❑	Alcohol
❑	❑	❑	Bath Salts (Not the kind in your tub)
❑	❑	❑	Benzodiazepines (Xanax, Ativan, Valium)
❑	❑	❑	Caffeine (Coffee, tea, energy drinks, caffeine pills)
❑	❑	❑	Cannabis (THC – CBD oil with THC, smoking, edibles)
❑	❑	❑	CBD oil without THC
❑	❑	❑	Ecstasy (MDMA/Molly)
❑	❑	❑	Heroin
❑	❑	❑	Hallucinogens (LSD)
❑	❑	❑	Inhalants (Huffing)
❑	❑	❑	Kratom
❑	❑	❑	Methamphetamines
❑	❑	❑	Magic Mushrooms
❑	❑	❑	Pain Pills
❑	❑	❑	PCP (Angel Dust)
❑	❑	❑	Peyote
❑	❑	❑	Spice (Synthetic marijuana)
❑	❑	❑	Steroids
❑	❑	❑	Tobacco (Any form)
❑	❑	❑	Vaping (Any Substance)

Were any of these administered via IV? ❑ Yes ❑ No

Thank you