Initial Evaluation Template

Demographic Information

(Please complete all questions on this form)

Date:________________

Name:____
Address:____
____
Phone (Home):_____________________ Phone (Work): ______________________
Date of Birth: ______________________ Social Security #: ______________________
Guardianship (for children and adults when applicable): ______________________________

Marital Status (check one)
[] Never Married
[] Married
[] Widowed
[] Divorced
[] Separated
[] Cohabiting

Race (optional)
[] White
[] African-American
[] Hispanic
[] Native American
[] Asian
[] Other

Gender: [] Male [] Female
Age: ___________

Family Members:

Name	Age	Sex	Relationship

Employer: _____________________________Occupation: ______________________________
School (for children, and adults when applicable): _____________________________________

Referral Source: ____

Insurance Information:
Insurance Company/HMO: _______________________________Phone: ____________
Member ID# _______________________ Managed Care Company_______________
Claims Address: ______________________________________Phone: ____________

Emergency Information:
Name of Emergency Contact: ___________________________ Phone: ____________
Relationship to Patient: ___________________________________

Advance Directives:
I have an Advanced Directive/Instruction for Mental Health Treatment. ____YES ____ NO