

ACCESS HEALTH TREATMENT CENTER

**CONFIDENTIAL PATIENT INTAKE FORM**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GENERAL INFORMATION:**

|  |  |  |
| --- | --- | --- |
| **NAME:** | **Race:**  | **MR #:**  |
| **ADDRESS:** |
| **CITY: STATE: ZIP:** |
| **PHONE #: HOME: WORK: CELL:** |

**EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DRIVER LIC. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Height: \_\_\_\_\_\_\_ Weight: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_\_ Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE DO NOT CONTACT ME AT: HOME \_\_\_\_ WORK:\_\_\_\_ CELL: \_\_\_\_\_ EMAIL: \_\_\_\_\_ MAIL: \_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **SEX: Male: 🖵 Female: 🖵**  | **Date of Birth:**  | **Age:** | **SS#:**  |
| **EMPLOYER:** | **OCCUPATION/TITLE:** |
| **ADDRESS OF EMPLOYER:**  |
| **HOURS PER WEEK:** | **YEARS ON JOB:**  | **HIGHEST LEVEL OF EDUCATION COMPLETED:** |

**RELATIONSHIP INFORMATION:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **MARITAL STATUS:** | **SINGLE 🖵** | **ENGAGED 🖵** | **MARRIED 🖵** | **SEPARATED 🖵** | **DIVORCED 🖵** | **WIDOWED 🖵** |
| **If Engaged, Married, Separated, Divorced, or Widowed, how long has it been?** |
| **NAME OF SPOUSE:** | **SPOUSE AGE:** |
| **SPOUSE’S OCCUPATION:**  |
| Name of Emergency Contact: | Phone #:  |
| Have you ever been treated in a treatment program before? | YES: \_\_\_\_\_\_\_ | NO: \_\_\_\_\_\_ |
| If Yes, Please give name and address of the Treatment Center:  |
| Last Date of Treatment: | Name of Counselor: |

**PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**