

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