Barkley & Associates, Inc.

Client Information Form

Client # ____________

Please Complete all Entries

Minor or Dependent Client (18 years or younger): Name	Sex M F	Date of Birth	Age
Client or Guardian of Dependent Above: Name	Sex M F	Date of Birth	Age

Address: (Street)	Marital Status Single Married Divorced Widowed Separated	Education
(City, State, Zip)	Home Phone Number: ( )	Social Security Number:

Name of Employer: (Client or Guardian)	Occupation:	Work Phone Number: ( )	May we contact you at work? Y N
Employer Address: (Street, City, State, Zip			

Name of Spouse:	Spouse Social Security Number:	Date of Birth	Age

Spouse's Employer:	Spouse Work Phone: ( )
Family Physician:	Phone Number: ( )
Nearest Relative Not Living with You:	Phone Number: ( )
Nearest Friend Not Living with You:	Phone Number: ( )

<u>**In Case of Emergency:**</u>	Phone Number: ( )	**Okay to Contact** Yes No
Who referred you to our Facility?	Phone Number: ( )	
Who is Financially Responsible for Payment?	**Preferred Method of Payment::** Cash Check Visa MasterCard	

Previous Mental Health Services? Yes No

Name of Facility	Location	Date	Outcome

Household Information: Name of Persons living with you

Name	Relationship	Date of Birth	Place of work/ School

****<u>PLEASE COMPLETE OTHER SIDE</u>****

Medical Information

This is a confidential record of medical information. No information can be released without your written consent.

Name of Family Physician ________________________ Date of last visit________________________

Please check all symptoms you have had now or in the past:

______	Headaches	______	Night Sweats	______	Backaches
______	Fainting	______	Frequent Coughs	______	Change in Bodily senses
______	Dizziness	______	Shortness of Breath	______	Numbness:____________
______	Change in Vision	______	Palpitations	______	Easy Bruising
______	Earaches	______	Swelling of Hands or Feet	______	Rashes
______	Ringing of Ears	______	Venereal Disease (STDS)	______	Changes in Skin or Hair
______	Loss of Hearing	______	Stomach Pains	______	Irregular Periods
______	Nose Bleeds	______	Nausea or Vomiting	______	Miscarriage
______	Frequent Colds	______	Abnormal Cramping	______	Abortion
______	Allergies	______	Difficulty with Bowel Regularity	______	Chest Pains
______	Difficulty Swallowing	______	Pain Urinating	______	Other:______________

Medical Allergies:____

List any surgeries:____

List all current medications: (including over-the-counter drugs) and doses:

____ ____

____ ____

Do you smoke?	Yes	No	How Much?______________________
Recent Weight Changes?	Yes	No	Explain______________________
Sleeping Difficulties?	Yes	No	Explain______________________
Thoughts of Dying?	Yes	No	Explain______________________
Do you drink quantities of coffee, coke, or tea?	Yes	No	Explain______________________
Are you Accident Prone?	Yes	No	Explain:______________________

Has any blood relative ever had: (Please include which relative)			
Cancer	Diabetes	Tuberculosis	High Blood Pressure
Stroke	Alcoholism	Nervous Breakdown	Heart Trouble

Insurance Information

Primary Insurance:	Address	City, State, Zip	Phone Number
Name of Insured	Relationship	ID Number	Group Number
Other Insurance:	Address	City, State Zip	Phone Number
Name of Insured	Relationship	ID Number	Group Number

I hereby apply for services offered by **BARKLEY AND ASSOCIATES, INC,** as may be appropriate to me or my child. I have received a copy of **BARKLEY AND ASSOCIATES, INC.'s** Fee Policy and I understand and agree that I am ultimately responsible for payment of services.

____ ________________________

Signature Date