

POWESHIEK COUNTY MENTAL HEALTH CENTER CONSUMER INFORMATION

Please check if filled out by: _____ child or by _____ parent (or other adult) for child

Child Information:

Date _____
 Last Name _____ First Name _____ MI _____
 Date of Birth _____ Social Security # _____ (Medicaid ID# _____)
 Street Address _____ Apt or Box # _____
 City _____ State _____ Zip _____ County _____
 Home Phone Number () _____ Parents work ph# () _____ Parents cell# _____
 Ethnicity (circle choice): Is child a citizen of: Sex _____
 White/Caucasian _____ U.S.
 African American _____ Other Nationality (please specify _____)
 Hispanic _____
 American Indian _____
 Asian/Pacific Islander _____
 Mixed/Unknown _____
 Other _____

School _____
 Current Grade or Highest Grade Completed _____
 Current Teacher _____
 Who referred child here (include yourself)? _____
 Why? _____

Living Arrangements:

1. _____ Live with parent(s)
2. _____ Live with other relative(s) (specify: _____)
3. _____ Live in foster home
4. _____ Live in shelter/group home/halfway house)Where? _____
5. _____ Other (specify: _____)

Insurance Information:

Insured's Name _____ Date of Birth _____
 Address _____ City _____ State _____ Phone _____
 Relationship to child (parent, guardian, other) _____ Sex _____ Male _____ Female
 Social Security Number _____ Employer _____
 *Primary Insurance _____
 Insurance Number _____ Group # _____
 *Secondary Insurance _____
 Insurance Number _____ Group # _____
 Person responsible for the bill:
 Name _____ Phone _____
 Address _____ City _____ State _____

Person to contact in case of Emergency:

Name _____ Relationship _____ Phone _____
 Address _____ City _____ State _____

Signed _____ **Date** _____

(Signature of adult responsible for this visit)

Family Information:

Father's Name: _____ DOB _____ SS# _____

Address _____ City _____ State _____ Zip _____ Phone _____

Employer _____ Work Phone _____

Mother's Name _____ DOB _____ SS# _____

Address _____ City _____ State _____ Zip _____ Phone _____

Employer _____ Work Phone _____

Legal Guardian: _____ Address and Phone if different from parents, above: _____

<u>Siblings</u>	<u>Birth Dates</u>	<u>Living at Home?</u>

Other people living in the home besides those listed above?(If yes, give names and relationship to child:)

Marital Status of Parent(s) with whom child is living(Circle Choice)

- 1. Never Married
 - 2. Married
 - 3. Divorced
 - 4. Widowed
 - 5. Separated
- Is parent a U.S. citizen?
Yes No

Employment Status of Parent(s) with whom child is living

- 1. Full time
- 2. Part time
- 3. Homemaker
- 4. Retired
- 5. Not employed
- 6. Disabled

Annual Household Income

- (for statistics only)
- 1. \$0 - 10,000
 - 2. \$10,000 - 20,000
 - 3. \$20,000 - 30,000
 - 4. \$30,000 - 40,000
 - 5. Over \$40,000

Medical Information:

Has child ever been seen before by a mental health professional? _____

If yes:

When _____ Where _____ By Whom _____

Current Medications (Prescription and over-the-counter) _____

Drug allergies/sensitivities _____

Food reactions _____

Physical Health Problems _____

Physician _____ Phone _____

Pharmacy _____ Phone _____