ALLIED BEHAVIORAL HEALTH

Client Information

Client Name: ____ **Today's Date:** __________________

Birth Date: ______________ **Male**____ **Female**___ **SS#**_______________________________________

Address: _________________________ **City:** _______________________ **State:** _______ **Zip:** __________

Phone: Home: ____________________ **Work:** ______________________ **Cell:** _______________________

Emergency Contact **Name:** __________________________________ **Phone** _________________________________

Relationship to Client ____

Education: _______________________________________ **Marital Status:** __________________________

Occupation: ____

Employer: ____

Physician: Name ____ **Phone** _____________________________

Address ____

Referred By: ____

Insurance: ____

ID # _____________________________________ **Group #** ______________________________

Policy Holder: Name ____

SS# ____ **DOB** ___________________________

Address ____

City _______________________________ **State** _______ **ZIP CODE** _______________

For Office Use Only:

Clinician ____ **Title** ______________________

DSM Diagnosis ____ **Date:** ______________________

Medical History (Attach any lab results or consultation reports as appropriate)

Surgeries (List separately) Date Outcome

Chronic Illnesses (Check all that apply)

	Self	Family	Date of diagnosis
Diabetes:			
Hypertension:			
Cancer:			
Epilepsy/Seizures:			
Asthma:			
Heart Disease:			
Stroke:			
Lung Disease:			
Headaches/Migraines:			
Arthritis:			
Other (List):			

Allergies (Leave blank if you have none) Reactions:

Medications:

Food:

Environmental:

Other:

Medications (Prescribed and OTC)

Current (List Separately)	Dose	Date Started	Refills	Prescribing MD

Past (List Separately)	Dose	Date Started	Refills	Prescribing M

RELEASE OF INFORMATION TO PRIMARY CARE PHYSICIAN (PCP)

I understand that my records are protected under Federal Regulation 42CFR and under the general laws of my state, and cannot be released without written consent, except as specifically stated by law.

I understand that, under federal law, the provider named below may release information from my records, without my consent, when:

A. There is an indication of child abuse or abuse of disabled adults.
B. Given the best clinical judgment, there is threat to the safety to self or others (suicidal or homicidal).
C. Required to present records to comply with a court order.

This authorization expires ninety (90) days from today's date. I understand that I may revoke my authorization to release information at any time in writing, and such revocation will be effective on the date of receipt of my revocation.

I, ______________________________________, residing at, ______________________________________
Name Address

____, hereby give my informed **consent** for

____ to talk with and/or release written
Name of Provider

documentation, regarding my treatment to ____.
Name of PCP

____ ____________________________________
Signature of Client Signature of Parent or Guardian

____
Date

********OR********

I, ____, **do not consent** to information being released to my
Name
Primary Care Physician.

____ ____________________________________
Signature of Client Signature of Parent or Guardian

____
Date