# Initial Evaluation Template

## Demographic Information

(Please complete all questions on this form)

Date:_____

Name:_____

Address:_____

_____

Phone (Home):_____ Phone (Work): _____

Date of Birth: _____ Social Security #: _____

Guardianship (for children and adults when applicable): _____

Marital Status (check one)

[] Never Married [] Divorced

[] Married [] Separated

[] Widowed [] Cohabiting

Race (optional)

[] White [] Native American

[] African-American [] Asian

[] Hispanic [] Other

Gender: [] Male [] Female

Age: _____

Family Members:

| Name | Age | Sex | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Employer: _____Occupation: _____

School (for children, and adults when applicable): _____

Referral Source: _____

**Insurance Information:**

Insurance Company/HMO: _____Phone: _____

Member ID# _____ Managed Care Company_____

Claims Address: _____Phone: _____

**Emergency Information:**

Name of Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

**Advance Directives:**

I have an Advanced Directive/Instruction for Mental Health Treatment. ____YES ____ NO