CLIENT INFORMATION

____
Client's Name

____
Address – Street, City, State, Zip Code

Social Security # ______________________ Date of Birth ____________ (MM/DD/YY) Gender: F○ M○ T○

I authorize JFS to contact me via mail, telephone, text and/or email.

(_____)__________	__________	(_____)__________	__________
Cellphone #	Cell Provider	Home Telephone #	E-Mail Address

- Single ○ Married ○ Separated ○ Divorced ○ Widowed ○ Living with someone ○
- Jewish ○ Non-Jewish ○

Parent 1 ○ Guardian ○:	Parent 2 ○ Guardian ○:
______________ Name	______________ Name
______________ Address (if different than above)	______________ Address (if different than above)
______________ Telephone #	______________ Telephone #

Medical Insurance ______________________________________

Family Physician ______________________ Telephone #______________

Other mental health treatment(s) - Yes ○ No ○

If yes, with whom ______________________ Date(s) ______________

Do you already have an Advance Health Care Directive? Yes ○ No ○ If yes, please provide a copy for your chart.

If no, you can visit the website *http://oag.ca.gov/search-results/?query=advance+directive*

Medication(s) Currently Being Taken______________________________

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State client's problem briefly______________________________

Where did you learn about JFS? ______________________________

EMERGENCY CONTACT INFORMATION

______________	______________	______________
Name	Telephone #	Relationship

____
Address – Street, City, State, Zip Code

______________	______________	______________
Print Name of person completing this form	**Signature**	**Today's Date**