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 # Home Telephone # E-Mail Address

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

Parent 1 ○ Guardian ○:

_____
Name

_____
Address (if different than above)

_____
Telephone #

Parent 2 ○ Guardian ○:

_____
Name

_____
Address (if different than above)

_____
Telephone #

Medical Insurance _____

Family Physician _____ Telephone #_____

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

If yes, with whom _____ Date(s) _____

Medication(s) Currently Being Taken

_____

State client's problem briefly_____

Where did you learn about JFS? _____

EMERGENCY CONTACT INFORMATION

_____ _____
Name and Relationship Telephone #

_____
Address – Street, City, State, Zip Code

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

Last Revision 7/27/15