WEST BERGEN MENTAL HEALTHCARE
APPLICATION FOR TREATMENT SERVICES – Adult

Today's Date:_____ Name of Client:_____
Date of Birth:_____ SS#:_____ How did you hear about West Bergen?_____
_____
Address:_____
Street City, State, Zip Code
Home Phone:_____ Cell Phone:_____Bus. Phone:_____
E-mail (optional):_____

Client's Education Level:
Grammar School_____ High School_____ College _____ Post-Grad_____

Client's Marital Status:
Never Married/Minor Child____ Married____ Separated_____ Divorced____ Widowed____ Domestic Partner___

Client's Ethnicity:
American Indian/Alaskan___ Asian/Pacific Islander___ African American___ Hispanic___ White___ Other_____

Client's Sex: Male____ Female_____

(To be filled out, if applicable)
Parent/Guardian #1
Name:_____ SS#:_____ DOB:_____
Home Address & Phone: (if different from above)_____
Parent/Guardian #2
Name:_____ SS#:_____ DOB:_____
Home Address & Phone: (if different from above)_____
Parents'/Guardian Marital Status:_____
Please list every member of your household:

Name	Date of Birth	Sex	Ethnicity (if different from above)	Relationship

Insurance Information: Policy Holder's Name:_____
Insurance Company: _____
Member ID Number: _____ Group ID Number: _____

Who's financially responsible for payment of services? _____
Home Address & Phone: (if different from above)_____

→→→→→→***Please Fill Out Back of Page***←←←←←←

For Office Use ONLY – TO BE COMPLETED BY INTAKE THERAPIST
Date of Intake:_____ Diag. _____ Dept. _____ Therapist: _____

PLEASE PRINT

Who is your primary physician?

Name and Address: _____

Are you being treated for any medication condition and/or taking any medication? Yes____ No ___

If yes, please describe: _____

_____

_____

What has led you to seek treatment at this time?

_____

_____

_____

How long have you been concerned about what has brought you to treatment? _____

Have you or a family member ever been treated at West Bergen? Yes____ No ___

If yes, by whom and when?_____

_____

Have you previously consulted with a Mental Health Professional? Yes____ No ___

If yes, who, where, and dates: _____

_____

Have you ever been hospitalized for mental health problems? Yes____ No ___

If yes, where and dates: _____

_____

There may be times when your therapist would consider it important to speak with a family member or friend as part of making a thorough assessment or otherwise supporting your treatment. This communication would take place only with persons whom you designate and with your knowledge and consent. Please check one of the following:

☐ Yes, I would give my person for such communication. (Please sign consent forms)

☐ No, I would prefer not to have any communication concerning my treatment shared with family or friends.

In the event of an emergency, whom may we contact?

Name	Address	Phone

We would appreciate it if you would provide us with any other information that you believe is important to a fuller understanding of you and your circumstances.

_____

_____

_____