YOUTHS EATING SMART
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Client Information Sheet

Name _____ Age _____ Gender M F

Marital Status _____

Name(s) and DOB for all other family members _____

_____

_____

Home address (city, state, zip code)_____

Home phone _____ Work phone(s) _____

Cell phone(s) _____

Daytime phone where you can be reached or a message left regarding appointments _____

All calls are discreet. Please note any restrictions or limitations regarding messages to be left, or your ability to discuss your situation while at this number _____

_____

_____

_____

Client's date of birth _____ Social security number _____

Insured/Responsible party for fees (if other than client) _____

(Please provide copies of any legal paperwork that documents financial responsibility for psychotherapy fees)

Insured's relationship to client _____

Insured's social security number _____

Insured's date of birth _____

Insurance Company [Please provide a copy of your insurance card(s)]*_____

Address (city, state, zip code) _____

ID/Policy #/Group # _____

*If you have more than one insurance company, please list insurance company name and address for all additional insurances _____

_____

_____

List Symptoms/Complaints _____

_____

_____

_____

Date symptom(s)/Complaint started _____

_____

Date of service and names of provider(s) of any previous treatment(s) and/or evaluation(s) _____

_____

_____

_____

_____

List your primary care physician and other specialists you see _____

_____

_____

Address of primary care physician _____

When was your last comprehensive medical evaluation? _____

What was the outcome of this last evaluation? _____

Please list any medications you are taking and who prescribed the medication _____

_____

_____

_____

_____

Welcome

Welcome to Youths Eating Smart and Montclair Health Associates.. This document provides important information about you so we can have the YES program meet your needs. Regardless of the information you provide, our approach to your situation will depend or a variety of factors, including your present difficulties, your history and prior treatment received. *Thanks for letting us help.*