* REQUIRED INFORMATION

DATE *

Enter date here

SOCIAL SECURITY NUMBER *

Enter number here

FIRST NAME *

Enter first name here

MIDDLE NAME

Enter middle name here

LAST NAME *

Enter last name here

ADDRESS *

Enter address here

CITY *

Enter city here

STATE *

Please select state.

ZIP *

Enter zip here

HOME PHONE

+1 (phone number)

CELL PHONE

+1 (phone number)

WORK PHONE

+1 (phone number)

EXT

Enter ext here

OK TO LEAVE A MESSAGE ON MACHINE AT HOME?

Yes

No

OK TO LEAVE A MESSAGE WITH A FAMILY MEMBER?

Yes ○ No ○

OK TO LEAVE A MESSAGE AT WORK (VOICEMAIL)?

Yes ○ No ○

EMAIL *

Enter email here

OK TO LEAVE A MESSAGE ON CELL PHONE?

Yes ○ No ○

DATE OF BIRTH

Enter date here

AGE

Enter age here

GUARDIANSHIP (ADULTS WHEN APPLICABLE)

Enter name here

ROLE IN FAMILY UNIT CIRCLE ONE

Mother ○ Daughter ○ Son ○

Husband ○ Other ○

GENDER

MARITAL STATUS

Male Female Sing Mar d Divc d Sep te

EMPLOYER OR SCHOOL (IF APPLICABLE)

Enter employer or school here

EMPLOYMENT STATUS

Enter status here

OCCUPATION

Enter occupation here

ADDRESS

Enter address here

Emergency Contact

FIRST NAME

Enter first name here

LAST NAME

Enter last name here

RELATIONSHIP TO PATIENT

Enter relationship here

ADDRESS

Enter address here

CITY

Enter city here

STATE

Please select state.

ZIP

Enter zip here

HOME PHONE

CELL PHONE

Enter number here

Enter number here

I authorize You First Health and Wellness Services LLC to contact the above-named person in case of an emergency.

REFERRAL SOURCE

Insuranc | Internet | Friend

THERAPIST

Mental Health Therapist/MD | Facility

FIRST NAME

Enter first name here

MIDDLE NAME

Enter middle name here

LAST NAME

Enter last name here

ADDRESS

Enter address here

CITY

Enter city here

STATE

Please select state.

ZIP

Enter zip here

PHONE

+1 (phone number)

Pharmacy Information

PHARMACY NAME

Enter name here

ADDRESS

Enter address here

PHONE

+1 (phone number)

LIST ALL PSYCHIATRIC MEDICATIONS THAT YOU ARE CURRENTLY TAKING

NAME OF MEDICATION

DOSAGE/FREQUENCY

Enter medication here	Enter dosage or frequency here
Enter medication here	Enter dosage or frequency here
Enter medication here	Enter dosage or frequency here
Enter medication here	Enter dosage or frequency here
Enter medication here	Enter dosage or frequency here

Patient-Provider Authorizations and Agreements.

Authorizations and Agreements with You First Health and Wellness Services LLC. Please read carefully and sign. The paragraphs below contain several agreements.

PATIENTS NAME

Enter name here

DATE

Enter date here

Financial Responsibility

☐ I understand and agree that I am responsible for the fees to You First Health and Wellness Services LLC before services are rendered.

Primary Care Physician Contact Authorization

PRIMARY CARE PHYSICIAN'S NAME

Enter name here

ADDRESS

Enter address here

TELEPHONE NUMBER

Enter number here

FAX NUMBER

Enter number here

I, (Print Name)

Enter name here

hereby authorize You First Health and Wellness Services LLC

PLEASE CHECK ONE

- To release any applicable mental health information to my primary care physician (PCP) above
- To release any applicable substance abuse information to my PCP named above
- To release only medical information to my PCP named above
- Not to release any information to my PCP named above
- I DO NOT HAVE A PCP AT THIS TIME

☐ I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. If I do not revoke this authorization, it will expire one (1) year after I have terminated treatment.

PATIENT OR GUARDIAN NAME

Enter name here

DATE

Enter date here

Informed Consent For Treatment

Enter name here

(name of patient), agree and consent to participate in behavioral healthcare services offered and provided by You First Health and Wellness Services LLC, a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above-named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) within scope of license, certification, and training of the behavioral health care provider directly supervising the services received by the patient.

PATIENT NAME

Enter name here

DATE

Enter date here

RELATIONSHIP TO PATIENT (IF APPLICABLE)

Enter relationship here