South Shore Mental Health Counseling Services, P.C.

**SCREENING INFORMATION**

**General Information** Date_____

Client's First Name_____ Last Name_____

Address_____ City_____ Zip_____

Birthdate____/____/____ Age_____ Gender_____ SSN_____

Preferred Phone Number_____ C/ H/ W May we leave voice/text messages: Y N

Alternate Phone Number_____ C/ H/ W May we leave voice/text messages: Y N

**Emergency Information**

In case of emergency, contact: Name _____

Relationship_____ Phone_____

**Medical Information**

Primary Physician_____ Phone_____

Psychiatrist_____ Phone_____

Allergies_____ Current Medications_____

_____

**Insurance Information**

Primary Insurance_____ Phone #_____

ID# _____ Subscriber Name_____

Group #_____ Subscriber Date of Birth____/____/____

Client's Relationship to Subscriber_____

Email Address:_____

How did you hear about us?_____

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