

Lee Mental Health Center, Inc.
Client Demographic Form

Date: _____

Case ID: _____

Client Information

Last Name: _____ First Name: _____ MI: _____ Suffix: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

County: _____ Cell Phone: _____

Home Phone: _____ Alternate Phone: _____

SSN: _____ If not provided, Reason: _____

DOB: _____ Actual Estimated (circle one)

Ethnicity: _____ Race: _____

Gender: MALE FEMALE Marital Status: _____

Employment Status: _____ Residential Status: _____

Highest Completed Level of Education: _____ Primary Language: _____

Veteran of US Armed Forces: YES NO UNKNOWN

Alias/AKA Maiden name: _____

Emergency Notification Information:

Emergency Contact Name: _____ Relationship: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Spouse/Parent/Next of Kin: _____ Relationship: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Legal Information:

Legal Status: _____

Guardian Name: _____ Relationship: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Employer: _____ Employer Phone: _____

Age _____ Height _____ Weight _____

Family or Primary Care Physician _____

Date of Last Visit _____

- 1. Has your doctor ever said you have heart trouble? Yes No
- 2. Have you ever had pains in your chest? Yes No
- 3. Do you often feel faint or have spells of dizziness? Yes No
- 4. Has a doctor said your blood pressure is too high? Yes No
- 5. Do you suffer from diabetes? Yes No

If yes, how often do you test? _____

- 6. Have you been in the hospital in the last year? Yes No

If so, please list date of last admission and reason for hospitalization. _____

- 7. Are you currently taking any prescribed medications or over the counter medications? Yes No

If yes, please list all current medications you are taking, including over the counter medications _____

- 8. Do you have bladder or bowel control problems? Yes No
- 9. Do you suffer from asthma or breathing difficulties? Yes No
- 10. Do you suffer from epilepsy? Yes No

If yes, when was your last seizure? _____

- 11. Has your Doctor told you that you have Hepatitis or HIV Infection? Yes No

- 12. Have you used alcohol or drugs in the past 24 hours? Yes No

If yes, please list all and the amounts used _____

- 13. Is there a possibility of you being pregnant? Yes No

- 14. Is there any other medical issue we need to be aware of? Yes No

Please specify _____

- 15. List any childhood illnesses _____

- 16. Are your immunizations up to date? Yes No

I understand I am responsible for providing LMHC, to the best of my knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to my health.

Client Signature (or Parent / Guardian / Legal Custodian)

Date

Staff Use Only

_____ **Client has not identified any medical issues and will be referred to PCP on annual basis**

_____ **Client will be referred to Assessment RN for medical appropriateness for admission.**

_____ **Client is referred to hospital for medical evaluation (because) _____**

_____ **Client sent out 911 for medical emergency (because) _____**

Reviewed by _____ **CLINICIAN** Date: _____

Reviewed by _____ **RN** Date: _____

CLIENT NAME: _____ CASE #: _____