

PEAK WELLNESS CENTER - CLIENT APPLICATION

PLEASE PRINT

Today's date: _____

Client's full legal name: _____ Maiden Name: _____

Marital status: _____ Spouse or Parent/Guardian name: _____

Residential address: _____ City: _____ State: _____ Zip: _____

Mailing Address if different: _____ County: _____

Home phone: _____ Work phone: _____ Soc. Sec.: _____

Message phone: _____ Best times and place to contact: _____

Please sign if you give permission to leave messages: _____ Highest grade completed: _____

Veteran?: _____ Birth date: _____ Place of Birth: _____ Mother's name: _____

Race (circle one): White Black Native American Asian Pacific Islander Other: _____

Hispanic Origin (circle one): None Cuban Puerto Rican Mexican Other Hispanic: _____

Emergency Contact Name: _____ Phone Number(s): _____

Emergency Contact Address: _____

Do you consider this to be an emergency? YES / NO (If YES, please advise a staff person immediately)

Describe what brings you to the Center: _____

Do legal problems bring you to Peak Wellness? YES / NO Please explain: _____

Have you been seen by PWC before? YES / NO When? _____ If yes, under what name? _____

Who referred you to PWC? _____ From: _____

Please list other agencies with which you (or your child) are involved: _____

Your Gender: Male / Female Pregnant?: _____ # of Dependent Children: _____

Please list everyone in addition to you who is residing in your home. Also include dependents not living with you.

Name:	Sex	Age	Relationship to you	Client # (For office use only)

FOR OFFICE USE ONLY:

Client #: _____ Account #: _____ Therapist #: _____ Agency: _____

SS# Release: YES NO Client Fee: _____ Primary Liability: _____ Secondary Liability: _____

FINANCIAL INFORMATION

Person responsible for payment: _____ Telephone: _____

Address: _____

Employment: Full-time / Part-time / Unemployed / Retired / Disabled / Homemaker / Child under 15 / Child 15 or over

Employer: _____ Work phone: _____

Occupation/job title: _____ Gross Annual income: _____

Spouse's Employer: _____ Work Phone: _____

Spouse's Occupation/job title: _____ Gross Annual income: _____

Unemployment compensation? _____ SSI?: _____ SSDI?: _____ Retirement?: _____

Other sources of income: _____ Amount: _____ Total Annual income: _____

INSURANCE INFORMATION Please submit insurance card for copying

Equality Care / Medicaid? YES / NO #: _____

Medicare? YES / NO #: _____

Kid Care? YES / NO #: _____

Health Insurance? YES / NO

Insurance Company: _____ Name of Policy Holder: _____

Birth date of Policy Holder: _____ Client's Relationship to Policy Holder: _____

Subscriber ID. #: _____ Group ID #: _____

2nd Health Insurance? YES/ NO

Insurance Company: _____ Name of Policy Holder: _____

Birth date of Policy Holder: _____ Client's Relationship to Policy Holder: _____

Subscriber ID. #: _____ Group ID #: _____

FOR OFFICE USE ONLY:

Date of Insurance Verification: _____ Referral required: YES / NO: _____

Pre-Authorization Number: _____ Pre-Authorization Period: _____

Number of Authorized Visits: _____ Initials: _____

Comments:

YOUTH HEALTH HISTORY

Name: _____ Date of Birth: _____

What medical problems does the child have? _____

Age: _____ Height: _____ Weight: _____ School Grade: _____

Does the child use tobacco? _____ How much each day? _____

Does the child use alcohol? _____ How much, how often? _____

What non-prescribed drugs does the child use? _____

Did the child's mother use tobacco, alcohol or drugs during the pregnancy? Yes / No

Primary Care Physician name, address and telephone #: _____

Please list all prescription and non-prescription medications the child is currently taking.

Medication	Dosage	Frequency	For what reason?	Prescribing Physician

Does the child have any allergies? _____

Does the child have any circumstances that will require accommodations? Yes / No

Please describe any serious medical problems the child has had in the past: _____

Has the child had any problems (past or present) with any of the following?

Comments:

Vision	Yes/No	_____
Speech	Yes/No	_____
Hearing	Yes/No	_____
Learning	Yes/No	_____
Learning to:		
Ø Sit up	Yes/No	_____
Ø Crawl	Yes/No	_____
Ø Talk	Yes/No	_____
Ø Walk	Yes/No	_____
Ø Toilet	Yes/No	_____

Is the child up-to-date with immunizations? Yes / No

What school is your child attending? _____ Grade? _____

How is the child doing in school? _____

Does the child receive special services in school? _____

Please add any comments about the child's health you would like to share with us. _____

Person completing form and relationship to child: _____
