CENTURY MENTAL HEALTH, INC.

5570 Sterrett Place, Suite 101 ● Columbia, Maryland 21044 Tel: 410.730.0552 Fax: 410.715.4720

CLIENT INFORMATION FORM

(please print very clearly)

| Today's Date// | / Date of F | irst Appointment | //_ | | |
|---|---------------------|------------------|----------|--|--|
| Month Day | Year | Month | Day Year | | |
| Client's Name: | | | | | |
| First | Middle | | Last | | |
| | | | | | |
| Client's Date of Birth: (DOB)/_ | | | | | |
| Month | Day Year | | | | |
| Gender identity/preferred pronouns: | | | | | |
| 2 | | | | | |
| Client's Address: | | | | | |
| Client's Address:Street | City | State | Zip Code | | |
| | | | | | |
| Home phone: () | Your email | | | | |
| | | | | | |
| Work phone: () | Cell phone: | () - | | | |
| In case of emergency, please contact: | | | | | |
| | | | | | |
| Name | Phone: | | | | |
| Forestle | Dalatia waliwa ta | -l'4 | | | |
| Email: | Relationship to | client | | | |
| | | | | | |
| *Name of Parent /Guardian (if client is a | | | | | |
| *Address of Donort (Occording (C. F. | First | Middle | Last | | |
| *Address of Parent /Guardian (if client lives at a different address) | | | | | |
| | | | | | |
| Street | City | State | Zip Code | | |
| *Phone of Parent/ Guardian H. (|) - W (|) - C/ | <u> </u> | | |
| Thone of Farency Guardian II. | | | | | |
| *Email of Parent/Guardian: | | | | | |
| | | | | | |
| Insurance Company: | Insurance Policy #: | | Group# | | |
| | | | | | |
| Subscriber's Name: Relationship to you: | | | | | |
| | | | | | |
| Referred by (i.e., self, parent, friend, doctor) | | | _ | | |
| | | | | | |
| Name of Primary Care Doctor/phone | ! | | | | |

Century Mental Health, Inc.

Medications

| Name | | | | | | |
|---|-------------------|---------|---------------------------------|--|--|--|
| Please list your medications, their purpose and the prescribing physician | | | | | | |
| Date prescribed | Medication/Dosage | Purpose | Prescribing Physician/Contact # | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Signature | | Data | | | | |