Consumer Face Sheet

Initial Face Sheet ☐ Updated ☐: _____*Please check current services:*
☐ Outpatient ☐ Assessment only

Consumer Name:	First Middle/Maiden

Sex: _____ **GENDER IDENTITY:** _____
Marital Status: ___ single; no partner ___ single, steady partner ___ living together ____ married ____ separated ___ divorced ___ widowed ____ other
Primary Language: ___ E=English; ___ F=French; ___ S=Spanish; ___ L=Sign Language; ___O=Other;
Note possible communication difficulties.
Do you have any hearing or vision issues? Y or N
Do you wear glasses, contact lenses or hearing aids? Y or N
What is your dominant hand? Left right ambidextrous
RACE (OPTIONAL): AMERICAN INDIAN OR ALASKA NATIVE ASIAN BLACK OR AFRICAN AMERICAN
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER WHITE OTHER RACE
ETHNICITY (OPTIONAL): HISPANIC OR LATINO NOT HISPANIC OR LATINO
Home Phone: _____(message: Y/N) Work Phone: _____(message: Y/N)
Cell Phone: _____(message: Y/N) Email: _____(message: Y/N)
PREFERRED PHONE (circle one): H W C **What is the best way to contact you?**
DATE OF BIRTH: _____
WHO REFERRED YOU TO Mr. Clemens?
_____
__
PATIENT EMPLOYER INFORMATION: EMPLOYED STUDENT OTHER
Emergency Contact(s): Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____
(Please use additional pages if you need more space to respond to any of the questions)

Address:	
Referral Source:	
Legal Guardian:	
Guardian Address:	
Social Security#:	
No. of children and ages:	
Spouse's name	
Previous marriage	
Need for Special Accommodations:	

Current Medications:	☐None Reported ☐ Yes; Explain:
Reported Allergies:	☐None Reported ☐ Yes; Explain:
Other MH Providers:	
Date of last physical	
Health problems	
Medical Providers:	
Dental Provider:	
Hospital Preference:	
Advanced Directives	☐None Reported ☐ Yes; Explain:
Emergency Contacts:	Name:
	Name:
	Name:
Any previous hospitalizations?	

What is the primary concern or problem for which you are seeking help?

Precipitating Event(s): When did the problems begin? _

How severe is your problem (1= mildly or mildly incapacitating; 2=moderate or moderately incapacitating; 3=severe or severely incapacitating)? _

What makes it better? What makes it worse?

Are there any ***immediate*** challenges or issues that need our attention? Yes/No If yes, please describe.

What do believe to be the cause of your current problems?

Completed by: _____ Date: _____