WEST IOWA COMMUNITY MENTAL HEALTH CENTER
FACE SHEET

Date: _____ Social Security Number: _____ Case Number: _____

NAME OF PERSON SEEKING TREATMENT: _____
Maiden or Former Name(s): _____
Address: _____ Phone: _____ Message: Yes/No
County of Residence: _____ County of Legal Settlement: _____
Would you like us to communicate with you by alternative means or at alternative locations? Yes/No
If yes, alternative address or phone? _____ OK to leave message? Yes/No
Other request: _____
Emergency Contact: _____ Phone Number: _____
Referral Source: _____
Present Medication: _____
Pharmacy: _____
Family Physician: _____ Phone Number: _____
Physician Address: _____
Allergies: _____
Race ____ Prior Inpatient Mental Health: Yes/No | Legal Status (circle one) Voluntary Court Ordered
Method of Payment: 1) _____ 2) _____
Policyholder: _____ Policy Number: _____
Ins. Address: _____ Ins. Phone:
EMPLOYMENT STATUS OF CLIENT BEING SEEN: (CIRCLE ONE) Full-Time Part-Time Homemaker
Retired Student Unemployed Disabled Child
Patient and / or Guardian Employer: _____ Employer Phone: _____
Employer's Address: _____
Adjusted Gross Income: _____
Legal Guardian/Payee/Conservator: _____
Guardian Address: _____
Guardian Phone: _____
Guardian Social Security Number _____

FAMILY MEMBER LIVING IN THE HOME (PLEASE INCLUDE YOURSELF) *IDENTIFIED CLIENT

Name Last	First	Relationship To Client	Age	DOB	Sex	Marital Status	Occupation
*		SELF					

*Office Use Only:
Therapist: _____
Diagnostic Impression after 1st interview: _____
Sliding Fee: _____