NORTHSIDE BEHAVIORAL HEALTH CENTER

MR# (Office Use Only):	Date:	Social Security#: _______ - ______ - _________
Last Name:	First Name:	Middle Initial:
Address 1 (Mailing):		
Address 2 (Physical):		
City:	State:	Zip: County:
Gender: ___Male ___ Female	**Date of Birth:**	**Age:**
Home Phone: ( )	Work Phone: ( )	Other Phone: ( )
Who referred you to Northside?		

Employment Status (circle one)

If Working: Full Time Active Military Part Time Unpaid (Family Business)

If Not Working: Homemaker Student Disabled/Unable to Work Criminal Inmate Inmate-Other Not Authorized to Work Retired On Leave of Absence Unemployed (in Labor Force)

Marital Status (circle one): Single Married Divorced Separated Widow Cohabitate Child Reg Domestic Partner

Primary Language:	**Language(s) Spoken:**

Race (circle one): White Black Native American Alaska Native Asian Hawaiian/Pacific Islander Multi Racial Other

Ethnicity (circle one): Puerto Rican Mexican Cuban Mexican -American Haitian Other Latino Non-Hispanic Other Hispanic None of the Above

Religion:

Education Level:

No Years of Schooling	Associate Degree	Doctorate Degree
Kindergarten	Bachelor Degree	Special School
Nursery School/Preschool/Head Start	Master Degree	Vocational School
School Grade: ______	Professional Degree	College Undergraduate Year 1 2 3 4
High School Graduate (Diploma/GED		

Living Arrangements (circle one)

Assisted Living Facility (ALF)	Hospital	Mental Health Assisted Living Facility (ALF)
Dependent Living - with Non-Relative	Independent Living – Alone	Nursing Home
Dependent Living - with Relatives	Independent Living - with Non-Relatives	Other: ____________________
Foster Care/Home	Independent Living - with Relatives	Group Home (Residential, Rehab, etc.)
Homeless	Jail or Correctional Facility	Supported Housing

Current Living Situation (circle one): Stable Homeless Shelter Streets

Veteran Status

Military Service Yes No	**Military Related Disability** Yes No

If you answered “NO” to service question – Please STOP and go to the “DISABILITY STATUS” on next page

Military Status:	Active	Reserve	National Guard	Inactive	Veteran	Retired
Last Branch of Service:	Air Force	Army	Coast Guard	Marines	Navy	Public Health
Discharge Type:	Honorable	General	Medical	Dishonorable		
Discharge Year:						

Insurance/Guarantor Information			
Circle One Insurance Type: No Insurance Medicaid Private Insurance Medicare Other: ____________________			
Private Insurance Name:		Policy #:	
Address:			
Phone #:			
Name of Person Financially Responsible:		Relationship:	
Address of Person Financially Responsible:			
Phone # of Person Financially Responsible:			
SSN #:_________-_______-_____________	Gender: Male Female	DOB: ____ / ____ / _______	
Employment Status:			
Employer Name:			
Employer Address:			
Emergency Contact:			
Name:	Relationship:	Living with you? Yes No	
Address:			
City:	State:	Zip:	County:
Home Phone: ( )	Work Phone: ( )	Other Phone: ( )	
Individual Income: $ **Circle One**: Weekly Bi Weekly Monthly Yearly			
Total Family Income: $ **Circle One**: Weekly Bi Weekly Monthly Yearly			
Additional Source of Income (circle): SSI SSDI AFDC Food Stamps Cash (SSI) Child Support Other:_______			
Number of Children in Household:		Number of Adults in Household:	
Disability Status - please circle Yes or No:			
Hearing Disability	Yes No		
Physical Disability	Yes No		
Visual Disability	Yes No		
Speech Disability	Yes No		
Learning Disability	Yes No		
Limited English	Yes No		
Next Of Kin			
Name:		Relationship:	
Address:			
City:	State:	Zip:	Phone: ( )
Does the individual seeking services have a Legal Guardian: Yes No			
If YES, Legal Guardian's Name:			

My signature is to certify that the above information is true and accurate.

_______________________________ _________________

Signature of Individual Completing Form **Date**

Last Name: ____

First Name: ____

MR#: ____