

**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 #: \_\_\_\_\_

2<sup>nd</sup> 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:

## ADULT HEALTH HISTORY

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

What medical problems do you currently have? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Do you use tobacco products? \_\_\_\_\_ How much, how often? \_\_\_\_\_

Do you use alcohol? \_\_\_\_\_ How much, how often? \_\_\_\_\_

What non-prescribed drugs do you use? \_\_\_\_\_

Primary Care Physician name, address and telephone #: \_\_\_\_\_

\_\_\_\_\_

Please list all prescription and non-prescription medications you are currently taking.

Medication	Dosage	Frequency	For what reason?	Prescribing Physician

Any Allergies? \_\_\_\_\_

Do you require any accommodations or have any special needs? Yes / No

Please describe any serious medical problems you have had in the past. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please add any comments about your health you would like to share with us. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_