PEAK WELLNESS CENTER APPLICATION

What you need to provide to apply:

- **Photo Identification** (Examples are driver's license, passport, student ID)
- **Income Verification** (Examples are most recent tax return or current pay stubs, unemployment benefit letter or denial letter, worker's compensation statement)
- **Private Insurance Coverage Card(s), Medicare Card, Medicaid or Equality Care Card**

Today's Date: Client's Social Security #: Responsible Party SS#:	Si nececitas esta forma en Espanol por favor avisanos. What language do you speak? ☐ English ☐Spanish ☐Other What language do you write? ☐English ☐Spanish ☐Other Did someone complete this form on your behalf? ☐Yes ☐No	Peak wellness | center

Legal Last Name of Client	Legal First Name and M.I.	Client's Birth Date	Client's Gender M F	Client's Maiden Name
Physical Address	City	State	Zip Code	County
Mailing Address /P.O. Box	City	State	Zip Code	County

Home Phone	Initial if OK to leave message_____ Message Phone:	Is client a U.S. citizen? ☐Yes ☐No	Client's Marital Status (check one) ☐Divorced ☐Legally Separated ☐Married ☐Minor Child ☐Never Married ☐Widowed
Cell Phone	Work Phone	Email Address	

Client's Race (check one) ☐American Indian/Alaska Native ☐Asian ☐Black ☐Native Hawaiian / Pacific Islander ☐Other / Multi Racial ☐White	Client's Ethnicity (check one) ☐Cuban ☐Mexican ☐Not-Hispanic ☐Puerto Rican ☐Other Hispanic / Latino	Client's Housing Information (check one) ☐Foster home ☐Group Home ☐Homeless ☐HUD/CHA ☐Jail ☐Own ☐Rent Free ☐Rent ☐Residential Treatment ☐Hospital	Is the client a veteran? ☐No ☐Combat ☐Non-Combat

Client's Employment Status (check one):	Client's Employer Name	Client's Employer Phone Number

☐Child(U-16) ☐Disabled ☐Full Time ☐Homemaker ☐Inmate ☐Part Time ☐Self Employed / Other ☐Retired ☐Student(16+) ☐Unemployed ☐Volunteer		Client's Employer Address	Date Hired

Emergency Contact Name	Emergency Contact Phone Number	Emergency Contact Relationship to Client

Recently lost employment? ☐Yes ☐No	Client's Place of Birth (city, county, state)	Highest Grade Client Completed: ☐No Schooling ☐ Please indicate grade completed between K and 11: _____ ☐High School /GED ☐1 Year of College ☐2 Years of College/Associates Degree ☐3 Years of College ☐Bachelor's Degree ☐Master's Degree ☐Doctoral Degree
	Client's Mother's First Name	

(For Dependents Only) Name of Parent/Legal Guardian	(For Dependents Only) Relationship to Client	Parent / Guardian Phone (if different from client)

Describe what brings you to Peak Wellness Center:

Do you consider this to be an emergency? ☐Yes ☐No (If YES, please advise a staff person immediately)

Do legal problems bring you to Peak Wellness Center?
☐No ☐Yes Please explain:

Have you been seen by Peak Wellness Center before?
☐No ☐Yes When? If yes, under what name?

Who referred you to Peak Wellness Center?

Please list other agencies or providers with which you (or your child) are involved:

Pregnant? ☐Yes ☐No	Number of dependent children:

NAME: _____

CLIENT'S HEALTH HISTORY

Height: Weight:	Name of family physician(s):	Have you seen you family physician in the past year? Yes / No	Do you require any accommodations or have any special needs? Yes / No Explain:

Check all that apply to your current health status

Alcohol/Drug Problems		Hearing Problems		Sleep Disorder	
Alzheimer's/Dementia		Heart Disease		Stroke	
Arthritis		High Blood Pressure		Thyroid Problems	
Blood Disorder		HIV/AIDS		Tobacco Use	
Breathing Problems		Liver Problems/Hepatitis		Tuberculosis	
Cancer		Mental Illness		Urinary/Kidney Problems	
Diabetes		Pain		Vision Problems	
Gastro-Intestinal Problems		Seizures/Neurological Problems		Weight Problems	

Other:

Rapid Alcohol Problems Screen (RAPS4)	Yes	No
1. Have you had a feeling of guilt or remorse after drinking or using drugs?		
2. Has a friend or a family member ever told you about things you said or did while you were drinking or using drugs that you could not remember?		
3. Have you failed to do what was normally expected of you because of drinking or drug use?		
4. Do you sometimes take a drink or use drugs when you first get up in the morning?		

PHQ-2 During the past 2 weeks, have you been bothered by:	Not at All	Several Days	More than half the Days	Nearly Every Day
1. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed or hopeless?	0	1	2	3

NAME:_____

Current Medications:	Dosage	Frequency	Prescriber	Helpful? (Yes or No)
Prescriptions:				
Over the Counter:				
Homeopathic:				
Allergies:				

FEE DISCOUNT APPLICATION

NAME:_____

Please provide copy of most recent tax return:

Insurance Coverage (please have cards available for copying)

- ☐ None
- ☐ My Private Insurance
- ☐ Other's Private Insurance
- ☐ Other: _____
- ☐ Medicare
- ☐ Medicaid
- ☐ Kid Care CHIP

Office Use Only

Household Income: _____ based on

☐ Tax Return ☐ Pay Stubs ☐ Other: _____

Number in household: _____

Fee Level (%): _____

Household. Please list all household members claimed on your tax return other than the client (Use other side if needed)

Name: Gender: M / F Birthdate: ☐Spouse ☐Parent ☐Child ☐Step-Parent ☐Step-Child ☐Other: ☐Sibling	Name: Gender: M / F Birthdate: ☐Spouse ☐Parent ☐Child ☐Step-Parent ☐Step-Child ☐Other: ☐Sibling	Name: Gender: M / F Birthdate: ☐Spouse ☐Parent ☐Child ☐Step-Parent ☐Step-Child ☐Other: ☐Sibling
Name: Gender: M / F Birthdate: ☐Spouse ☐Parent ☐Child ☐Step-Parent ☐Step-Child ☐Other: ☐Sibling	Name: Gender: M / F Birthdate: ☐Spouse ☐Parent ☐Child ☐Step-Parent ☐Step-Child ☐Other: ☐Sibling	Name: Gender: M / F Birthdate: ☐Spouse ☐Parent ☐Child ☐Step-Parent ☐Step-Child ☐Other: ☐Sibling