|  |  |  |
| --- | --- | --- |
| **Name** |  | |
| **Address** |  | |
| **Phone(s)** | **VM OK?** Yes No | |
| **Date Of Birth** |  | |
| **Email** |  | |
| **Emergency Contact** |  | |
| **Phone** |  | |
| **Primary Care Provider** |  | |
| **Address / Phone / Fax** |  | |
| **Medication Provider** |  | |
| **Address / Phone / Fax** |  | |
| **Current Behavioral Medications** |  | |
| **Medication Allergies** |  | |
| **Other Medical Issues** |  | |
| **Hospitalization, Suicide and Self Harm** | | |
| **Suicide Attempts (how many)** | |  |
| **Inpatient for Behavioral Health (how many / where)** | |  |
| **Inpatient Chemical Dependency (how many / where)** | |  |
| **Intensive Outpatient MH / DBT / CD (how many / where)** | |  |
| **Self Harm – cutting / burning (How many years).** | |  |