Hillcrest Family Services
Demographic Form

Client Legal Name: _____
(Last) *(First)* *(MI)* *(Suffix)*

Alias/Maiden Name: _____
(Last) *(First)* *(MI)*

Client Address: _____

City/State/Zip: _____ **County:** _____

Mailing Address: *(if different)* _____

City/State/Zip: _____

OK to send mail? ○ **Yes** ○ **No** ○ **Unknown**

Primary Phone #: _____ Special Calling Instructions: _____

Work Phone #: _____ Special Calling Instructions: _____

Other Phone #: _____ Special Calling Instructions: _____

Email Address: _____ **OK to send email?** ○ **Yes** ○ **No**

Client Legal Status: ○ **Adult** ○ **Adult with Guardian** ○ **Minor with Guardian** ○ **Emancipated Minor**

Legal Guardian Name: _____ **Relationship to Client:** _____

Address: _____

City/State/Zip: _____ **Phone:** _____

Does Client have an Emergency Contact? ○ **Yes** ○ **No**

Emergency Contact Name: _____ **Relationship to Client:** _____

Address: _____

City/State/Zip: _____ **Phone:** _____

Date of Birth: _____ **Gender:** ○ **Male** ○ **Female** ○ **Transgender**

Social Security #: _____ Reason why SS# not provided: _____

Race: _____ **Marital Status:** _____ **Ethnicity:** _____

Language: _____ **Religion:** _____ **Is this person in special education:** ○ **Yes** ○ **No**

Last Grade Completed: _____ **School:** _____

Interpreter needed? ○ **Yes** ○ **No** **School District:** _____

Employment Status: _____ **Household Income:** _____

Living Arrangement: _____ **Household Composition:** _____
(foster care, group home, etc.) *(single adult, significant other, etc.)*

Does Client have an Advance Directive? ○ **Yes** ○ **No**

Relationship Information *(Household Members Detail)*

Relationship:____________________ If other, please specify:____________________

Name:____________________ **DOB:**__________ **Gender:**__________

Address *(If different)*:______________________________

City/State/Zip:______________________________

Home Phone:____________________ **Work Phone:**____________________

Relationship:____________________ If other, please specify:____________________

Name:____________________ **DOB:**__________ **Gender:**__________

Address *(If different)*:______________________________

City/State/Zip:______________________________

Home Phone:____________________ **Work Phone:**____________________

Relationship:____________________ If other, please specify:____________________

Name:____________________ **DOB:**__________ **Gender:**__________

Address *(If different)*:______________________________

City/State/Zip:______________________________

Home Phone:____________________ **Work Phone:**____________________

Relationship:____________________ If other, please specify:____________________

Name:____________________ **DOB:**__________ **Gender:**__________

Address *(If different)*:______________________________

City/State/Zip:______________________________

Home Phone:____________________ **Work Phone:**____________________

Referral Source:____________________ **Referral Information:**____________________

Presenting Problem:

Scheduling Requirements:______________________________

Did the Client Provide the Information? ○ **Yes** ○ **No**

Name of person providing information: *(if not the client)*____________________

Relationship to Client:____________________ **Phone Number:**____________________

Signature: ______________________________ **Date:**____________________

Hillcrest Family Services
Client Insurance Form

Client Name:_____ **Date:**_____

Primary Insurance:

Insurance Name:_____ **Policy Number:**_____

Group

Number:_____ **Name:**_____

Policy Holder Information **If self, please indicate and skip rest of section*

Relationship to Insured:_____**Name:**_____

Address:_____

City/State/Zip:_____

Date of Birth:_____ **Sex:**_____

Secondary Insurance: *(If applicable)*

Insurance Name:_____ **Policy Number:**_____

Group

Number:_____ **Name:**_____

Policy Holder Information **If self, please indicate and skip rest of section*

Relationship to Insured:_____**Name:**_____

Address:_____

City/State/Zip:_____

Date of Birth:_____ **Sex:**_____

HILLCREST FAMILY SERVICES
Adult/Child Checklist

Adult Checklist - Please check all that apply to you:

- ☐ agitation
- ☐ change in appetite
- ☐ crying spells
- ☐ depressed/sad
- ☐ difficulty coping
- ☐ discouraged
- ☐ helplessness
- ☐ hopelessness
- ☐ irritable
- ☐ loss of concentration
- ☐ loss of energy
- ☐ loss of interest
- ☐ loss of motivation
- ☐ sense of guilt
- ☐ sleep difficulty
- ☐ thinking slowed
- ☐ weight gain/loss
- ☐ worthlessness
- ☐ suicidal ideation
- ☐ avoidant
- ☐ flashbacks
- ☐ insomnia
- ☐ nightmares
- ☐ chest tightness
- ☐ dizziness
- ☐ shortness of breath
- ☐ headaches
- ☐ irritable
- ☐ heart racing
- ☐ poor sleep
- ☐ restless
- ☐ tense nervous
- ☐ tiredness/fatigue
- ☐ trembling
- ☐ worry
- ☐ purges
- ☐ agitation
- ☐ dizzy
- ☐ excessiveness
- ☐ grandiose
- ☐ minimal sleep
- ☐ racing thoughts
- ☐ binges
- ☐ body image distortion
- ☐ fear of weight gain
- ☐ loss of menstrual cycle
- ☐ aggression
- ☐ cruelty
- ☐ destructive
- ☐ fights
- ☐ fire setting
- ☐ run away/truant
- ☐ theft
- ☐ compulsions
- ☐ obsessions
- ☐ angry
- ☐ argues
- ☐ blames others
- ☐ defiant
- ☐ agoraphobia
- ☐ chest pain
- ☐ de-realization
- ☐ heart racing
- ☐ shakes/trembles
- ☐ short of breath
- ☐ sweats
- ☐ nausea
- ☐ fear of dying
- ☐ vigilante
- ☐ distractible
- ☐ easily frustrated
- ☐ fails to complete tasks
- ☐ fidgety
- ☐ forgetful
- ☐ hyperactive
- ☐ impatient
- ☐ impulsive
- ☐ poor concentration
- ☐ poorly organized
- ☐ procrastinates
- ☐ reactive
- ☐ short attention span
- ☐ working below capacity
- ☐ startles
- ☐ trauma
- ☐ other

What primary concerns brought you here today? _____

_____

Child Checklist - Please check all characteristics that apply to your child:

- ☐ Abnormal thoughts/perceptions
- ☐ Anger outbursts
- ☐ Anxiety/nervousness
- ☐ Bedwetting
- ☐ Change in friends
- ☐ Concerns with sexual activity
- ☐ Crying spells
- ☐ Decreased energy & motivation
- ☐ Depressed
- ☐ Difficulty making decisions
- ☐ Doesn't follow directions
- ☐ Drinking/drug use
- ☐ Easily frustrated
- ☐ Fatigue
- ☐ Feelings of hopelessness
- ☐ Feelings of inferiority
- ☐ Flashbacks
- ☐ Headaches
- ☐ Hyperactive
- ☐ increased aggression
- ☐ Interest in setting fires
- ☐ Irritable
- ☐ Memory problems
- ☐ Nightmares
- ☐ No appetite
- ☐ Obsessions/compulsions
- ☐ Oppositional
- ☐ Perfectionist
- ☐ Physical abuse history
- ☐ Poor self-control
- ☐ Problems with concentration
- ☐ Problems with eating
- ☐ Runs away
- ☐ School problems
- ☐ Sexual abuse history
- ☐ Sleep difficulties
- ☐ Stomach trouble
- ☐ Temper tantrums
- ☐ Thoughts of hurting others
- ☐ Thoughts of hurting self
- ☐ Traumatic experience
- ☐ Tremors
- ☐ Trouble making or keeping friends
- ☐ Unable to relax
- ☐ Withdrawn
- ☐ Other

What primary concerns brought you here today? _____

_____