|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Last Name: |  |  | **Income Information** | **Amount** |
| First Name: |  |  | Supplemental Security Income (SSI) |  |
| D.O.B. : |  |  | Social Security Disability Income (SSDI) |  |
| Social Security: |  |  | Employment (monthly wages) |  |
| MA# : |  |  | Other |  |
| Telephone/Contact: |  |  |  |  |
| Address: |  | | | | |

|  |  |
| --- | --- |
| Physician/Therapist name: |  |
| Physician/Therapist phone# |  |
| Physician/Therapist fax#: |  |
| Physician/Therapist address: |  |

**DIAGNOSTIC INFORMATION**

|  |  |
| --- | --- |
| **AXIS I:** |  |
| **AXIS II:** |  |
| **AXIS III:** |  |
| **AXIS IV:** |  |
| **AXIS V (GAF):** |  |

**List current medications:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **MEDICATION** | **DOSE** | **ROUTE** | **FREQUENCY** | **REASON** |
| **1.** |  |  |  |  |
| **2.** |  |  |  |  |
| **3.** |  |  |  |  |
| **4.** |  |  |  |  |
| **5.** |  |  |  |  |

**List psychiatric history & hospitalizations (specify dates):**

**(Please check all that apply)**

**     **

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