YOUR JOURNEY, LLC

CLIENT DEMOGRAPHIC FORM

Client:	Client Case #	Client DOB:
Assigned Staff:	Mental Health ☐ CIS ☐	Admission Date:

CLIENT INFORMATION:

Gender: Female
Address:
Marital status: ☐married ☐partnered ☐widowed ☐single ☐divorced
Primary language: ☐English ☐French ☐Spanish ☐ASL ☐Other
Home phone: Work phone: Cell phone:
Occupational Status:
Disabled ☐ Yes ☐ No Disability Income ☐Yes ☐No Food stamps ☐Yes ☐No
Ethnicity: Religion:
Race: ☐white ☐black or African American ☐ American Indian or Alaska Native ☐Asian ☐Other
Emergency Contact: (name, address, phone):
Legal Guardian (if applicable) name, address, phone:
Primary Insurance: (name of insurance, name of subscriber (if not the client), insurance number and co-pay amount): self pay
Secondary Insurance: (name of insurance, name of subscriber (if not the client), insurance number and co-pay amount): n/a
Referral Source: ☐self ☐external provider ☐family/friend
ROI's for referral source completed? ☐Y ☐ Client declined ROI's for billing completed ☐Y ☐N ☐Client declined

Behavioral Health Diagnoses:

ICD-10 CODE	DSM-5 Description	Specifier(s) as appropriate

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Staff Signature and Credentials Date