

APPLICATION FOR SERVICES

To help us serve you better, please complete this form. (This information is confidential under the laws of the State of Kentucky. Some of the data will be used without any reference to you to create statistics that inform benefactors, grantors and others about our services.)

APPLICANT:

 Last name First Name Middle Initial

 Street (E-911) Address City State Zip Code

 Mailing Address (if different from above) County

 Directions to Home from Agency Location

 Phone Number/s (Home) (Work) (Cell) (Other)

 Birth Date Birthplace (City/State) Social Security Number Ethnic/Racial Identity

 Gender Marital Status (Single, D, M, Separated) Pertinent dates (wedding, separation, divorce, death)

 Religious Affiliation Church You Attend Emergency Contact (Name and Phone Number)

 Place of Employment/School Job Title Annual Household Income & Source/s

 Last Education Completed School/College/Program/Educational Facility

Who else lives in your household?

First and Last Name	M/F	Relationship	Birthdate	School (include grade) or Employment/Other Info

Please state your reason for coming to this agency _____

Who referred you to this agency? _____

Have you had counseling in the past? Yes or No If yes, when & with whom? _____

If yes, would you sign a release of information for us to request records? Yes or No

Do you take any prescribed medications? Yes or No If yes, list medications, dose, & frequency:

Do you use tobacco products? Yes or No If yes, what type, how often? _____

Do you drink alcohol? Yes or No If yes, approximately how many drinks per week? _____

Do you use anything else to change your mood? Yes or No If yes, what and how often?

Have you ever been abused? Yes or No If yes, circle type/s: Physical, Sexual, Emotional, Verbal, Neglect

If you are under the care of a doctor, please state who and for what reason _____

Has there been any history of physical or emotional illnesses in your family? Yes or No

If yes, please describe _____

Please indicate any legal difficulties you are having _____

Day and time you prefer an appointment _____

Is it OK to leave a message at home? Yes or No

When/Where is it best to contact you? _____

Do you have email? Yes or No If yes, email address: _____

Do you plan to use health insurance to pay for services? Yes or No

If yes, please provide a copy of your card (front & back) and an authorization for services from your insurance company. (Any required co-payment will be due at the time of service.)

Are you willing to help us evaluate our services by completing a questionnaire? Yes or No

If yes, please indicate address to which questionnaire should be sent if different from home address:

Is there anything else you think we should know to better serve you? _____

Signature of Applicant/s _____

(Parent/Guardian must sign with minor or dependent)

Date _____