Concord Counseling Services

DEMOGRAPHIC INFORMATION

Legal Name: | **Today's Date:**

Chosen Name (if different than above) | **Social Security Number:**

Address | **City** | **State** | **Zip**

County of Legal Residence

Home Phone | **Work Phone** | **Mobile Phone**

May we contact you at any of the numbers listed above?
☐ **Yes** ☐ **No**

If No, how may we contact you?

Gender
☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female

Age | **Date of Birth**

Race (check all that apply)
☐ W – White ☐ N – Native Am. ☐ P – Native Hawaiian/Other Pacific Islander ☐ Multiple Race ☐ Unknown
☐ B – Black/African Am. ☐ A – Asian ☐ M – Alaskan Native ☐ Other:_____

Ethnicity
☐ A – Puerto Rican ☐ B – Mexican ☐ C – Cuban ☐ D – Hispanic or Latino ☐ E – Not Hispanic or Latino

Marital Status
☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Separated ☐ Other:_____

Smoking Status
☐ Current every day smoker ☐ Current some day smoker ☐ Smoker, current status unknown ☐ Former smoker
☐ Never smoker ☐ Unknown if ever smoked ☐ Heavy tobacco user ☐ Light tobacco user

Primary Language

Do you need the assistance of an interpreter?
☐ No ☐ Yes ☐ American Sign Language
☐ Language Interpreter (specify)_____

Do you need assistance with visualization of material or alternate format?
☐ No ☐ Yes

Do you have an Advance Directive for Mental Health Treatment?
☐ Yes – please provide copy of the directive
☐ No – if you would like information about an Advance Directive please talk with the Intake Coordinator or your Clinician

Do you have a guardian? ☐ No ☐ Yes – please complete below and provide copy of guardianship papers

Guardian Name (include address, if available) | **Guardian Phone Number**

Emergency Contact | **Relationship** | **Phone Number:**
Address:

Reason for your visit | **Referral Source**