

# DEMOGRAPHIC DATA

## PATIENT INFORMATION

Client Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
Address: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
\_\_\_\_\_  
Phone Number (Home): \_\_\_\_\_ Work: \_\_\_\_\_  
Race/Ethnicity: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
Please Circle Highest Grade of School Completed: 7 8 9 10 11 12 13 14 15 16  
Are you a Student now? \_\_\_\_ Yes \_\_\_\_ No Are you a Veteran? \_\_\_\_ Yes \_\_\_\_ No  
Sex: F M Marital Status: M W D S  
Do you need any special assistance/accommodations (such as a wheelchair, interpreter)?  
\_\_\_\_\_

How did you find out about our services? \_\_\_\_\_

## EMERGENCY INFORMATION

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone Number (Home): \_\_\_\_\_ (Work): \_\_\_\_\_

## UNDER 18 YEARS OF AGE

\* Please fill out if client is under the age of 18.

MOTHER

FATHER

MOTHER		FATHER	
_____	Name	_____	
_____	Address	_____	
_____		_____	
_____	Phone #	_____	_____
Home	Work	Home	Work

Legal Guardian (If Other Than Parents): \_\_\_\_\_  
Address: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone Number (Home): \_\_\_\_\_ Work: \_\_\_\_\_  
Update: \_\_\_\_\_  
\_\_\_\_\_