

**ZUMBRO VALLEY MENTAL HEALTH CENTER
INTAKE DEMOGRAPHICS DATA**

Current MR#:

Today's Date: **Admission Date:** **Movement Date:**

Client Name: (First) (Middle) (Last)

Address:

City: **State:** **Zip Code:**

Home Phone **Work Phone** **Cell Phone** **Confidential Phone**

Other Known Names: **E-mail:**

EMERGENCY CONTACT:

Name: _____ **Relationship:** _____

Address: _____
(Street, Box Number) (City) (State) (Zip Code)

Does Emergency Contact Live with Client Yes No

Home Phone #: _____ **Work Phone #:** _____ **Cell Phone #:** _____

County of Residence: **County of Financial Responsibility:**

Client Date of Birth: **Social Security Number:**

Female: **Male:** **Primary Language:** **Veteran: Yes** **No**

Education: _____ **Last grade completed** High School Some College College Graduate

Race:

- American Indian or Alaska Native Asian White
 Black or African American Native Hawaiian/Pacific Islander

Ethnic Origin: (Check Those That Apply)

- Asian Indian Cambodian Chinese Filipino Guamanian Hawaiian
 Hmong Japanese Korean Laotian Maori Pakistani
 Samoan Tahitian Tai Dam Taiwanese Thai Vietnamese

Do you have Hispanic Heritage? Yes No

Marital Status: Single Married
 Divorced Widowed
 Separated Legally Separated

Admission Status: Voluntary
 Involuntary Court Hold Order
Date of CHO: _____

Living Arrangement: (Where you reside greater than 50% of the time)

- Alone Own Home/Apartment Nursing Home Board & Lodge/Care
 W/Spouse W/Spouse & Family Foster Care Other
 W/Children: Gender: M F Age: _____ Student: Yes No
(Use additional sheet to add M F _____ Yes No
more children) M F _____ Yes No

Employment Status: Full-time Part-time Student

Employer: _____

Occupation: _____ **Job Title:** _____

***Annual Individual Income Level:** \$ 0 - \$15,000 \$15,001 - \$30,000 \$30,001 - \$50,000
 \$ Over \$50,000 *Optional unless utilizing sliding fee

Gross Monthly Household income: **Number in Household:**

COMPLETE SPOUSE INFORMATION FOR ALL ADULT CLIENTS

Spouse Full Name: _____

Spouse Social Security Number: _____

Spouse Employer: _____

Spouse Date of Birth: _____

COMPLETE PARENT/GUARDIAN INFORMATION IF CLIENT IS A CHILD

Father's/Guardian Name: _____

Address: _____

City, State, Zip Code: _____

Home Phone #: _____ **Work Phone #:** _____ **Cell Phone #:** _____

Employer: _____

Social Security #: _____

Relationship to Client: Natural Step-parent Adoptive Other _____

Mother's/Guardian Name: _____

Address: _____

City, State, Zip Code: _____

Home Phone #: _____ **Work Phone #:** _____ **Cell Phone #:** _____

Employer: _____

Social Security #: _____

Relationship to Client: Natural Step-parent Adoptive Other _____

To better serve our community we would like to ask how you heard about Zumbro Valley MHC:

(Please check appropriate box and list name of county if county referred)

- County _____ Olmsted Medical Center Mayo Clinic Mayo Health System
 Physician (not Mayo, OMC) Family Service Rochester NAMI Rapid Access Clinic
 Legal (court, corrections) Parole Officer Newspaper Television
 Phone Book Radio Self Family Friend Internal ZV Referral