PLAN OF MD-DC,INC.

604 S. Frederick Avenue, Gaithersburg, MD 20877
(301) 301-740-8444 (301) 740-8455 fax

CLIENT INFORMATION FORM

DATE:

SPONSOR/RESPONSIBLE PARTY INFORMATION:

NAME

ADDRESS:

PHONE NUMBER:

EMAIL:

RELATIONSHIP TO CLIENT:

HOW DID YOU HEAR ABOUT PLAN?

CLIENT INFORMATION:

CLIENT NAME:

SS#	DOB:	GENDER: m f	RACE:
HAIR COLOR:	EYE COLOR:	HEIGHT:	WEIGHT:

ADDRESS:

PHONE:

EMAIL:

MARITAL STATUS: single married separated divorced widowed

ADDITIONAL EMERGENCY CONTACT NAME:

RELATIONSHIP TO CLIENT: PHONE:

ADDRESS:

SIGNIFICANT MEDICAL & PSYCHIATRIC PROBLEMS:

CURRENT MEDICATIONS:

BLOOD TYPE: **ALLERGIES:**

PRIMARY AND SECONDARY PSYCHIATRIC AND MEDICAL DIAGNOSES:

PHYSICIAN/THERAPIST NAMES	SPECIALTY	PHONE/ADDRESS

CURRENT DAY ACTIVITY OR EMPLOYMENT SITE	
NAME:	PHONE:
ADDRESS:	

HEALTH INSURANCE INFORMATION
PRIMARY HEALTH PLAN:

POLICY # PHONE:

SECONDARY HEALTH PLAN:

POLICY # PHONE:

PHARMACY ASSISTANCE #

OTHER:

INCOME/ENTITLEMENTS

SSI $ SSDI $

WAGES $ per__________ TEMHA $ /month

FOODSTAMPS $ /month RAP $ /month

TRUST $ /monthly OTHER:

Rep Payee:

Trustee:

Power of Attorney:

What are the presenting problems?

How can PLAN be of assistance?
Please select all that apply:

- Trust Services ☐
- Mental Health Counseling ☐
- Entitlements (public benefits, Social Security, etc.) ☐
- Housing ☐
- Treatment Coordination ☐
- Socialization ☐
- Other ☐ Please describe below:

Any current or history of suicidal behavior?
No
Yes ☐ **Please describe below:**

Any current or history of physical/verbal aggression?
No ☐
Yes ☐ **Please describe below:**

Any current or history of substance abuse?
No ☐
Yes ☐ **Please describe below:**

List all recent psychiatric hospitalizations (within last two years). Include name of hospital, dates of admission, and reasons for admission:

Any criminal/legal issues?
No ☐
Yes ☐ **Please describe and include probation/parole officer information below:**

Describe behaviors and symptoms which indicate instability:

Additional information: