

**Client’s Information**:

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_ **Title**: Mr./Mrs.\_\_ /Ms.\_\_\_

Date of Birth: Age: \_\_\_\_\_\_\_\_\_\_\_SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_ Male Female \_\_\_ Other

Client’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Phone #: Home\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_

Parents/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_

\_Marital status: \_\_\_ Married \_\_Divorce \_\_Separate \_\_\_\_ Single never married \_\_ other/explain:\_\_\_\_

Emergency contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency contact Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial responsibility for service rendered by Optimum Potential Community Services**:

Print name of responsible person: \_\_\_\_\_\_\_\_\_\_\_ Insurance Name: \_\_\_\_\_\_ Policy#:\_\_\_\_

Group# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone #:**\_\_\_\_\_\_\_\_\_\_\_ **Fax**: \_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking medication? Yes \_ No \_ Please list medications below:

Name of medication/s: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergy:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Parents/ caregiver/guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

OPCS Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

How did you hear about us? My Primary Care Physician \_\_ Therapist \_\_ School \_\_ Church \_\_ Other \_\_