

Client Demographic Questionnaire

Have you ever received treatment from Northeastern Center before? _____ yes _____ no

If Yes, under what name? _____

Do any of your family/relatives work for Northeastern Center, Inc? ____ Yes ____ No Who? _____

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Mailing Address (if Different from above):

Address: _____ City: _____ State: _____ Zip: _____

County of Residence: _____ Home Phone: _____ Cell Phone: _____ email: _____

Contact Preference: ____ Home Phone ____ Cell Phone Is it okay to call Home Phone #.:? _____

Social Security #: _____ Date of Birth: _____

Preferred Language: _____

Is an Interpreter Needed? ____ Yes ____ No If Yes, What Language? _____

Marital Status: ____ Single ____ Married/Living Together ____ Divorced ____ Widowed

Referred By: _____ Address: _____

Referral Phone Number: _____

Employer: _____ Address: _____

Emergency Contact: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Phone Number: _____

Family Doctor: _____ Address: _____

Person to be Billed: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Insurance Information:

Insurance Coverage Provided by: _____ Insured's SS#: _____

Insured Date of Birth: _____ Insurance ID#/Group #: _____

Household Income: _____ Total # in Household: _____

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