PATIENT LABEL

INTENSIVE OUTPATIENT PROGRAM

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ M.I. ______

Date of Birth: _____/_____/______ Age: ________ Social Security #: ________-________-________

Sex: ________________ Gender: ________________ Race: ________________

Relationship Status: ☐ Never Married ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed ☐ Partnered

Address: ____

City: ______________________ State: ______ County: ________________ Zip: __________

Home Phone: ______________________ *May we leave a message?* ☐ *Yes* ☐ *No*

Cell Phone: ______________________ *May we leave a message?* ☐ *Yes* ☐ *No*

Employer: ____

Occupation: ____

Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Self-employed ☐ Retired ☐ Student ☐ Other

PRIMARY INSURANCE CARDHOLDER INFORMATION

☐ **Same as above**

Last Name: ______________________ First Name: ______________________ M.I. ______

Date of Birth: _____/_____/______ Social Security #: ________-________-________ Relationship: ______________

Primary Cardholder's Address: ____

City: ______________________ State: ______ Zip: __________ Phone: ______________

Employer: ____

Occupation: ____

Cardholder's Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Self-employed ☐ Retired

EMERGENCY CONTACT INFORMATION

1) Name: ______________________________ Relationship: ______________________

Home Phone: ______________________ Cell Phone: ______________________

2) Name: ______________________________ Relationship: ______________________

Home Phone: ______________________ Cell Phone: ______________________

Do you have any Psychiatric Advance Directives? ☐ *Yes* ☐ *No*
If yes, please provide a copy of these documents.

Seton | Behavioral Health Care

INTENSIVE OUTPATIENT PROGRAM

Patient Name: ____

Patient label

Please write your initials next to each medication you are taking each week and mark an X if you have stopped taking it. If you have a new medication or a new dose of an existing medication, please write it at the bottom of the list. PLEASE DO NOT CROSS OUT MEDICATIONS OR DOSES! Ask your group leader if you have questions about this form.

[**FOR GROUP USE ONLY**]

Medication	Dose	Schedule	Prescribing Doctor	Week 1 Date:__/__/__	Week 2 __/__/__	Week 3 __/__/__	Week 4 __/__/__	Week 5 __/__/__	Week 6 __/__/__
Example: *Prozac*	*10 mg*	*Morning*	*Dr. John Doe*						

Clinician Initials & Date __________ __________ __________ __________ __________ _________

Physician Initials & Date __________ __________ __________ __________ __________ _________