



Chrysalis House Inc.
Outpatient Program/ Intensive Outpatient Program
New Client Registration Paperwork:

Client Identification:

First Name: _____ Middle Initial: _____ Last Name: _____
Date of Birth: _____ Age: _____ Identified Gender: _____
Social Security Number: _____

Contact Information:

Client Home Phone Number: _____ Cell phone: _____
Client Address: _____
City: _____ State: _____ Zip Code: _____
Email Address: _____
Client's Personal Representative/Guardian Name, (if applicable):

Client Emergency Contact Information:

Emergency Contact Person #1:

Name: _____ Relationship to you: _____
Phone Number: _____

Emergency Contact Person #2:(Optional)

Name: _____ Relationship to you: _____
Phone Number: _____

Insurance Information: (If applicable) *Leave if Blank if you don't have this information right now*

Primary Insurance Company: _____
Company Address: _____
City: _____ State: _____ Zip Code: _____
Company Phone Number: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____ Social Security Number: _____
Policy Holder's Place of Employment: _____
Policy ID Number: _____ Group Number: _____

Secondary Insurance: (if applicable) _____
Company Address: _____
City: _____ State: _____ Zip Code: _____
Company Phone Number: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____ Social Security Number: _____
Policy Holder's Place of Employment: _____
Policy ID Number: _____ Group Number: _____

Primary Care Physician:

Name: _____ Phone: _____

Date of last physical exam: _____

Are there any current medical conditions you are being treated for? If yes, explain.

Current Medications:

(List all medications, dose, frequency, and the prescribing physician)

Medication Allergies:

Food Allergies:

Mental Health and/or Substance Abuse Treatment:

Check if you have received any of the following in the PAST:

- Inpatient substance abuse treatment
- Intensive outpatient treatment
- Individual outpatient substance abuse therapy
- Group therapy for substance abuse
- Detox for substance abuse
- Inpatient psychiatric hospitalizations
- Intensive Outpatient Program for mental health concerns
- Outpatient therapy for mental health concerns
- Group therapy for mental health concerns
- Medication Assisted Treatment for substance abuse disorders (i.e. Methadone, Suboxone)
- Medication management for mental health concerns
- Drug Court
- Probation
- Parole
- DCBS
- Other: _____

Check if you are CURRENTLY participating in any of the following treatment(s):

- Inpatient substance abuse treatment
- Intensive outpatient treatment
- Individual outpatient substance abuse therapy
- Group therapy for substance abuse
- Detox for substance abuse
- Inpatient psychiatric hospitalizations
- Intensive Outpatient Program for mental health concerns
- Outpatient therapy for mental health concerns
- Group therapy for mental health concerns
- Medication Assisted Treatment for substance abuse disorders (i.e. Methadone, Suboxone)
- Medication management for mental health concerns
- Drug Court
- Probation
- Parole
- DCBS
- Other: _____

Referral Source:

How did you hear about Chrysalis House Outpatient Program? (Family member, friend, legal representative, other mental health professional, other)

Treatment Concerns:

What current concerns do you have that you wish to address in treatment?

List any recent stressors that you believe may have contributed to your emotional health/substance abuse concerns.

Please make note of any questions you have that you would like to address during your first appointment with your treatment provider:

Please bring your completed New Client Registration Paperwork with you for your first appointment. Thank you! We are looking forward to meeting with you!