Shepherd Center
SHARE MILITARY INITIATIVE

New Client Information Form

*Please submit your completed form to **shareadmissions@shepherd.org**. If this document contains Personal Health Information, it is recommended that you send it via encrypted email. If you are not confident of your email security configuration, Shepherd can provide a secure transmission method upon request. You can also fax it to 404-603-4419 or mail it to Shepherd Center, Attn: SHARE Admissions, 2020 Peachtree Road, Atlanta, GA 30309.*

Demographics:

Name:_____
Address:_____
City:_____State: _____Zip:_____
Email address: _____
Date of Birth:_____SSN:_____Race:_____
Home Phone:_____ Cell Phone: _____
Marital Status:_____Spouse/Partner's name: _____

Referral Information

☐ Self-Referral ☐ MD/VA Referral ☐ Other
Referring Provider:_____Date of Referral: _____
Department/Clinic:_____Facility Name/Location: _____
Phone Number:_____Fax Number: _____
Email: _____

Primary Care Physician

Name:_____
Address:_____
Phone Number:_____Fax Number: _____

Psychiatrist (if applicable)

Name:_____
Address:_____
Phone Number:_____Fax Number: _____

Insurance Information (Please provide copy of card):

Primary Insurance
Name:_____Policy:_____Group:_____
Address:_____
Phone Number: _____
Insurer Name:_____DOB:_____SSN: _____

Secondary Insurance
Name:_____Policy:_____Group:_____
Address:_____
Phone Number: _____
Insurer Name:_____DOB:_____SSN: _____

Military History:

Branch of service: ☐ Army ☐ Navy ☐ Air Force ☐ Marines ☐ Coast Guard
Dates of service: _____
MOS: _____ Job Title: _____
Duty status: ☐ Active Duty ☐ Retired ☐ Reserve ☐ National Guard ☐ Discharged
Time (years/months) in service: _____ Total _____ Active Duty
Rank at discharge: _____ Highest rank (if different from rank at discharge) _____
Type of discharge: ☐ Honorable ☐ General ☐ Other Than Honorable
Date of discharge: _____

Deployments:

Location/Theater	Dates of deployment/tour

Are you service connected for any medical condition? ☐ Yes ☐ No If yes, list condition and percentage:

Medical Condition	Rating

Current Symptoms: *Please check all that apply*

☐ Depression	☐ Hearing difficulties	☐ Headaches	☐ Sensitivity to light
☐ Anxiety	☐ Memory problems	☐ Decreased strength	☐ Vision difficulties
☐ Physical aggression/anger outbursts	☐ Problems making decisions	☐ Pain	☐ Blurred/double vision
☐ Suicidal Thoughts/Behavior	☐ Concentration problems	☐ Dizziness	☐ Eye fatigue
☐ Homicidal Thoughts/Behavior	☐ Difficulty solving problems	☐ Balance problems	
☐ Difficulty with Sleep	☐ Difficulty communicating clearly	☐ Impaired coordination	
☐ Social withdrawal/isolation	☐ Decreased cognitive endurance	☐ Seizures	
☐ Drug/alcohol misuse/abuse	☐ Sensitivity to sound		

Other symptoms: _____
_____
_____
Please provide us any details you would like us to know about your symptoms: _____
_____
_____

Brain Injury History:

Do you have a history of concussion/brain injury? ☐ Yes ☐ No If yes, explain: _____

_____

_____

If answered "yes" to above, is brain injury recognized by DoD or VA? ☐ Yes ☐ No

Loss of Consciousness: ☐ Yes ☐ No If yes, Length of Time: _____

Event: ☐ Fall ☐ Crash ☐ Blast (IED, mortar, rocket, etc) ☐ Other: _____

Other General Medical History: *Explain any other medical conditions*

_____

_____

_____

_____

Surgeries:

Have you had any surgeries? ☐ Yes ☐ No If yes, explain: _____

_____

_____

Do you have any pending surgeries or procedures? ☐ Yes ☐ No If yes, explain: _____

_____

Current Medications: *include prescribed, over-the-counter, and supplements*

Medication Name	Dose	Frequency

Do you require assistance from another person to help you manage your medications? ☐ Yes ☐ No
If yes, explain: _____

_____

Please list any allergies: _____

_____

Treatment History: *Check if you have received any of the following*

- ☐ Sleep Evaluation
- ☐ Neuropsych Evaluation
- ☐ Physical Therapy
- ☐ Speech Therapy
- ☐ Occupational Therapy
- ☐ Recreation Therapy
- ☐ Substance Use Treatment
- ☐ Inpatient Psychiatric Hospitalization
- ☐ Pain Management
- ☐ Psychology/ counseling
- ☐ Psychiatry
- ☐ Other_____

Social History:

Individuals living in your home with you:

Name	Age	Relationship

Support System:

Name	Location	Relationship (friend, family, clergy, etc)

Do you receive Caregiver Support through the VA? ☐ Yes ☐ No If yes, name of Caregiver: _____

Do you have an assigned Fiduciary? ☐ Yes ☐ No If yes, name of Fiduciary: _____

Employment Information: ☐ Employed ☐ Retired ☐ Disabled ☐ Student ☐ Volunteer

Employer/School/Volunteer Location Name (if applicable): _____

Highest level of education: _____

Are you experiencing any financial difficulties? If so, explain: _____

_____

Do you have any current or past legal issues? If so, explain: _____

_____

Do you have any upcoming plans (travel, commitments) that may prevent you from participating in treatment? If so, provide dates you will not be available for treatment? _____

_____

Miscellaneous:

Goals for therapy/reason for referral: _____

_____

_____