



Shepherd Center
SHARE MILITARY INITIATIVE

New Client Information Form

Complete all pages and fax to 404-603-4419 or email to shareadmissions@shepherd.org. You may also mail to Shepherd Center, Attn: SHARE Admissions, 2020 Peachtree Rd., NW, Atlanta, GA 30309-1465.

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

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

- | | | | |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> Sleep Evaluation | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Inpatient Psychiatric Hospitalization | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Neuropsych Evaluation | <input type="checkbox"/> Recreation Therapy | <input type="checkbox"/> Pain Management | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Substance Use Treatment | <input type="checkbox"/> Psychology/ counseling | |
| <input type="checkbox"/> Speech Therapy | | | |

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: _____

