PLEASE RETURN COMPLETED CMH INFORMATION FORM

Client Name (Print) _____ Relationship to Client _____
Address _____Apt/ Lot Number _____
City, State, Zip Code _____Email Address _____
Phone Number (Home) _____ (Cell) _____ Circle Preference Email/ Text/ Phone
Client Birthdate _____ Sex _____ Race _____Ethnicity _____Primary Language _____

***Signature*: _____ Date: _____**

Provider Information and Dates of Last Appointment/ Next Appointment

CMH Managing Physician _____ Last Appt _____ Next Appt_____
Primary Care _____ Last Appt _____ Next Appt_____
Service Coordination Provider _____ Last Appt _____ Next Appt_____
Dentist _____ Last Appt _____ Next Appt_____
Other Providers _____ Last Appt _____ Next Appt_____
Other Providers _____ Last Appt _____ Next Appt_____

Immunizations up to date? □ YES □ NO
Have you ever received any information about vaccines? □ YES □ NO
Medical/ Fire/ Disaster Plan in place? □ YES □ NO
Individualized Education Plan (IEP) □ YES □ NO
Individualized Service Plan (ISP) □ YES □ NO
Individualized Family Service Plan (IFSP) □ YES □ NO
504 Plan? □ YES □ NO
Comprehensive Service Plan (CSP) □ YES □ NO

List any additional diagnosis

_____
_____

List any allergies

_____

Current treatments, therapies, or medical supplies / equipment

_____
_____

List any barriers to care

_____

Medication List

Please select the preferred visit: □ Telehealth □ Home Visit □ Phone Call □ Office Visit □ Decline