8920 HOLLY AVE NE STE 102B ALBUQUERQUE, NM 87122
Phone: (505) 856-6880 FAX: (800) 714-4705

CLIENT INFORMATION FORM

PLEASE COMPLETE THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY.

IF YOU HAVE QUESTIONS OR NEED ASSISTANCE COMPLETING THIS FORM, PLEASE CONTACT OUR OFFICE AT (505) 856-6880 OR EMAIL AT ADMIN@BRIDGESINC.INFO

CLIENT'S NAME: ____

DATE OF BIRTH: _______/_______/______ GENDER: M F

PARENT/GUARDIAN NAME(S): ____

PARENT/GUARDIAN ADDRESS: ____

EMAIL: ____

PARENT/GUARDIAN PHONE: HOME ______________________ CELL ___________________

DATE COMPLETED: _______/_______/_______ COMPLETED BY:______________________

YOUR RELATIONSHIP TO CLIENT: ____

WHAT IS YOUR LANGUAGE PREFERENCE? ____

LIST ALL LANGUAGES REGULARLY SPOKEN WITH CLIENT: ____________________________

ARE THERE ANY CULTURAL OR RELIGIOUS CONSIDERATIONS YOU'D LIKE US TO BE AWARE OF:
_____ YES _____ NO

IF YES, PLEASE DESCRIBE: ____

PRIMARY DIAGNOSIS: _________________BY WHOM: _______________ DATE: __________

SECONDARY DIAGNOSIS (if any) ______________BY WHOM: ____________ DATE: _________

HOW DID YOU HEAR ABOUT BRIDGES? ____

PLEASE DESCRIBE ANY LEGAL STATUS OR ONGOING CONCERNS BRIDGES SHOULD BE AWARE OF (FOR EXAMPLE, CUSTODY, GUARDIANSHIP, CYFD INVOLVEMENT, ETC.):

____

____

DESCRIBE ANY CONCERNS YOU HAVE ABOUT THE CLIENT:

____

____

____

WHAT WOULD YOU LIKE THE CLIENT TO LEARN?

____

____

____

IS YOUR CHILD VERBAL?

____ YES ____ NO

____

DOES THE CLIENT HAVE TANTRUMS, BEHAVIOR OUTBURSTS, OR OTHER CHALLENGING BEHAVIORS? EXAMPLES: AGGRESSION, INAPPROPRIATE LANGUAGE, ETC.?

_____ YES _____NO IF YES, PLEASE DESCIBE:

____

____

____

WHAT WOULD YOU AS A PARENT/CAREGIVER LIKE TO LEARN OR RECEIVE SUPPORT WITH?

____

____

____

HAS THE CLIENT HAD A DEVELOPMENTAL OR SKILLS ASSESSMENT CONDUCTED BY ANOTHER SOURCE IN THE PAST (ie. VBMAPP, ABLLS, VINELAND, AFLS, PEAK, etc.) _____ YES _____NO

IF YES, PLEASE LIST BELOW

____

WHAT OTHER BRIDGES SERVICES ARE YOU INTERESTED IN (check all that apply)?

□Sibling Support Group □Social Skills Group

PLEASE LIST ALL CLIENT'S HOSPITALIZATIONS: (medical, psychiatric, and residential)

DATE REASON

____

EDUCATIONAL AND THERAPUTIC SERVICES

SCHOOL NAME: ____ CURRENT GRADE: ______

TYPE OF CLASS: (i.e. GENERAL EDUCATION, SPECIAL EDUCATION, INCLUSION)

____

ANY CURRENT OR PAST EARLY INTERVENTION SERVICES: _____ YES _____ NO

IF YES, PLEASE LIST THE PROGRAMS AND LOCATIONS:

____

____

PLEASE LIST PROVIDERS FOR **ALL SERVICES** CLIENT CURRENTLY RECEIVES:

(If any services are provided by the school please indicate as "school service")

SPEECH THERAPY: ____

OCCUPATIONAL THERAPY: ____

HIPPOTHERAPY: ____

COUNSELING: ____

FAMILY COUNSELING: ____

BEHAVIOR THERAPY: ____

PLAY THERAPY: ____

MUSIC THERAPY: ____

PHYSICAL THERAPY: ____

PSYCHIATIC/PSYCHOTROPIC MEDICATION MANAGEMENT: _____________________________

OTHER: ____

Bridges, Inc. | 8920 Holly Ave NE Suite 102B, Albuquerque, NM 87122 | 505-856-6880

Record of Insurance

INCLUDE A COPY OF ALL APPLICABLE AND CURRENT INSURANCE CARDS IN ORDER FOR US TO DETERMINE ELIGIBILITY OF SERVICES (MEDICAID AND PRIVATE INSURANCE) In order for Bridges, Inc. to properly submit claims for services rendered we require a record of all active insurance plans the client may be covered under. Please provide information below for all active insurance plans whether you believe the insurance plan will cover rendered services or not. Failure to disclose all active insurance plans may result in the responsible party becoming financially liable for the full balance of services performed.

Record of Insurance for: ____,

including, but not limited to: Primary coverage, Secondary coverage or Tertiary coverage.

	Insurance Name	Member #/Subscriber ID
Primary		
Secondary		
Tertiary		
Other: Grants, Trusts, etc.		

By signing you acknowledge all active insurance plans have been identified and all is correct and accurate to the best of your knowledge:

Signature: ____

Print: ______________________________________ Date: ____________________

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