

Confidential Self-Evaluation

Barth Clinic

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PLEASE PRINT

Date of Evaluation _____ Patient ID Number _____

Name _____ Home Phone () _____
First Last Nickname

Address _____ Work Phone () _____
Street • P.O. Box Apartment

City _____ State _____ Zip Code _____ Date of Birth _____
Month • Day • Year

Drivers License # _____ State _____ Age _____

Social Security Number _____ - ____ - ____ Height _____ Weight _____ Gender M F

Physician _____ Phone () _____
Name City

Personal Contact _____ Phone () _____
Name Relationship City

Family Member _____ Phone () _____
Name Relationship City

Ever been a patient here before? Yes No If Yes, When? _____

How did you learn about us?
(Check the one that influenced your decision the most)

- | | | |
|---|--|--|
| <input type="checkbox"/> Attorney/Court/Probation | <input type="checkbox"/> School | <input type="checkbox"/> Yellow Pages |
| <input type="checkbox"/> Chemical Dependency Agency/Detox | <input type="checkbox"/> Mental Health Counselor | <input type="checkbox"/> Family Member |
| <input type="checkbox"/> Physician or Hospital | <input type="checkbox"/> Native American Tribe | <input type="checkbox"/> Friend |
| <input type="checkbox"/> Insurance Company/Managed Care | <input type="checkbox"/> Other | <input type="checkbox"/> Former Patient/Alumni |
| <input type="checkbox"/> Employer/EAP/Union | | <input type="checkbox"/> Re-Admit/Relapse |

If you checked a box in the above columns please write the name _____

What do you expect from your appointment or treatment today?

What special needs or concerns should the staff be aware of for your evaluation?

