**Client Face Sheet**

|  |  |  |
| --- | --- | --- |
| **Client Name**:       | **DOB**:        | **SS#**:       |
| **Admission Date**:       | **Phone Number**:       | **Address**:       |
| **Advance Directives**: [ ] Full Code [ ] DNR [ ] N/A  |
| **Primary Diagnosis**:       | **Known Allergies**:       | **Preferred Hospital**:       |
| **Physician Name**:       | **Physician Phone**:       | **Pharmacy Name**:       | **Pharmacy Phone**:       |
| **POA Name**:       | **POA Phone**:       |
| **Marital Status**: [ ]  Single [ ]  Married [ ]  Separated/Divorced [ ]  Widowed - How long?       |
| **Lives:** [ ]  Alone [ ]  With:       | Primary Language:       | Other Language:       | Religion:       |
| **In Case of an Emergency Contact:** |
| **Primary Contact** |      [ ] *Check if same as POA* | **Secondary Contact** |       |
| Relationship to Client |       | Relationship to Client |       |
| Home Phone # |       | Home # |       |
| Work Phone # |       | Work Phone # |       |
| Cell # |       | Cell # |       |
| E-mail: |       | E-mail: |       |
| Address |       | Address |       |
| City/State/Zip |       | City/State/Zip |       |
| Other Information:       |