CRISIS WALK-IN FORM

AXISHealth System

PATIENT INFORMATION							
Last Name		First Name			Social Security #		
Date of Birth		Gender			Pronouns		
Mailing Address					Apartment/Unit #		
Physical Address					Apartment/Unit #		
City		State			Zip Code		
Day Phone		Cell Phone			Home Phone		

PRIMARY INSURANCE ***(Please note that we do NOT bill for Crisis services; this information is important for referral of services.)***	
Insurance Company Name:	Policy ID:

EMERGENCY CONTACT					
Name			Relationship		
Day Phone		Alt Phone		City/State	

REASON FOR VISIT			
What brings you in today? (Check all that apply.)	□ Feeling unsafe □ Feeling afraid □ Feelings of anxiety □ Relationship difficulties	□ Thoughts of harming self □ Substance abuse concerns □ Thoughts of harming others	□ Feeling hopeless □ Seeking information □ Other:_____ _____

MEDICAL INFORMATION		
Do you have any current medical concerns? □ Yes □ No		Have you ever experienced a head injury that caused you to lose consciousness? □ Yes □ No
Do you have a primary doctor?	□ Yes □ No	If yes, please write their name: If no, would you like a referral? □ Yes □ No

	Name of Medication	**Dose**
Current Medications		

REFERRED BY		
Who referred you to Crisis?	□ Self □ Family member/friend □ Therapist: _____	□ Doctor: _____ □ Probation/Court: _____ □ Other: _____

For Internal Use Only:

Date: _____ Time: _____ MRN _____