

**YOUTHS EATING SMART**  
**JULIE JASKIEWICZ, R.D., C.D.E.**  
**JUDY AMIR, L.C.S.W.**

**Montclair Health Associates**

Client Information Sheet

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender M F

Marital Status \_\_\_\_\_

Name(s) and DOB for all other family members \_\_\_\_\_

Home address (city, state, zip code) \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone(s) \_\_\_\_\_

Cell phone(s) \_\_\_\_\_

Daytime phone where you can be reached or a message left regarding appointments \_\_\_\_\_

All calls are discreet. Please note any restrictions or limitations regarding messages to be left, or your ability to discuss your situation while at this number \_\_\_\_\_

Client's date of birth \_\_\_\_\_ Social security number \_\_\_\_\_

Insured/Responsible party for fees (if other than client) \_\_\_\_\_

(Please provide copies of any legal paperwork that documents financial responsibility for psychotherapy fees)

Insured's relationship to client \_\_\_\_\_

Insured's social security number \_\_\_\_\_

Insured's date of birth \_\_\_\_\_

Insurance Company [Please provide a copy of your insurance card(s)]\* \_\_\_\_\_

Address (city, state, zip code) \_\_\_\_\_

ID/Policy #/Group # \_\_\_\_\_

\*If you have more than one insurance company, please list insurance company name and address for all additional insurances \_\_\_\_\_

List Symptoms/Complaints \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date symptom(s)/Complaint started \_\_\_\_\_  
\_\_\_\_\_

Date of service and names of provider(s) of any previous treatment(s) and/or evaluation(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List your primary care physician and other specialists you see \_\_\_\_\_  
\_\_\_\_\_

Address of primary care physician \_\_\_\_\_

When was your last comprehensive medical evaluation? \_\_\_\_\_

What was the outcome of this last evaluation? \_\_\_\_\_

Please list any medications you are taking and who prescribed the medication \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Welcome

*Welcome to Youths Eating Smart and Montclair Health Associates..* This document provides important information about you so we can have the YES program meet your needs. Regardless of the information you provide, our approach to your situation will depend on a variety of factors, including your present difficulties, your history and prior treatment received. *Thanks for letting us help.*