New Client Information

Instructions: Please complete the entire form and click 'Submit' to e-mail or print and fax to (720)213-1007.

First Name: ______________________ **Last Name:** ______________________

Other Names Used: ______________________

Street Address: ______________________

City: ____________ **State:** ______ **Zip:** ______ **County:** ________

Telephone Number ***(where you can be contacted during business hours):*** ______________________

Home ______________________ **Mobile:** ______________________

Last four (4) digits of Social Security Number: __________ **Date of Birth:** __________

Gender: ☐ Female ☐ Male **Marital Status:** ☐ Married ☐ Divorced ☐ Single

Profession:

☐ RN ☐ CRNA ☐ LPN ☐ NP ☐ Pharmacist

☐ Dentist ☐ Dental Hygenist ☐ Veterinarian ☐ Chiropractor

☐ Student of: ______________ ☐ Other: ______________

Have you ever been licensed in another state? ☐ YES ☐ NO

If YES, provide state(s): ______________ **License Number(s):** ______________

Education: ☐ Diploma ☐ Certificate ☐ DVM ☐ DDS

☐ Associates Degree ☐ Bachelors Degree ☐ Master's Degree ☐ Doctorate

☐ Student ☐ Other: ______________

List school where you graduated from healthcare training:

School: ______________________ **State:** ____________

Emergency Contact: ______________________

Relationship: ______________ **Daytime Phone:** ______________

Date of first contact with Peer Assistance Services: ______________

To your knowledge, have you been reported to the Department of Regulatory Agencies? ☐ YES ☐ NO

How were you referred to PAS?

☐ Coworker ☐ Attorney ☐ Supervisor ☐ EAP ☐ Self

☐ Licensure Board ☐ Spouse/Friend/Significant Other/Family ☐ I don't know

☐ Other: ______________________

Have you been with PAS before? ☐ YES ☐ NO **How many times?** 1 2 3

Have you been in a peer assistance program in another state? ☐ YES ☐ NO

If yes, what state? ______________ **When?** ______________

Client General Information - Continued

Work Setting: (at time of report)

- ☐ Agency ☐ Hospital ☐ Long-Term Care ☐ Retail
- ☐ School ☐ Research ☐ Private Office/Clinic/Ambulatory
- ☐ Private Practice ☐ Other (Specify): ____________________

Work Specialty (at time of reporting):

Nurse Related:

- ☐ Administration ☐ Anesthesia ☐ Education ☐ Emergency
- ☐ Gerontology ☐ Home Health ☐ Oncology ☐ ICU/CCU/Step-Down
- ☐ Med-Surg ☐ OB/GYN ☐ OR/PACU ☐ Pediatrics
- ☐ Psych ☐ Public Health ☐ Urology ☐ Non-Clinical
- ☐ None ☐ Other (Specify): ____________________

Dentist/Pharmacist Related:

- ☐ Retail ☐ Self-employed ☐ Research ☐ Hospital
- ☐ Education ☐ Private Practice ☐ Other: ____________________

Other Healthcare Professional Related:

- ☐ Private Practice ☐ Other: ____________________

Position (at time of reporting):

- ☐ Administrative/Executive ☐ Faculty ☐ Supervisor/Manager ☐ Self Employed
- ☐ Charge Nurse ☐ Educator ☐ Float ☐ Staff
- ☐ Traveler ☐ Other (Specify): ____________________

Employer (at time of incident and/or report): ____________________

Address: ____________________

City: ____________________ **State:** __________ **Zip:** ____________________

Phone: ____________________ **County:** ____________________

Years of experience in my licensed profession: ____________________

Please provide a brief description of why you have been referred to PAS:

Client General Information - Continued

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Previous and current Diagnoses (Physical, Mental and Substance use related):

Treatment Types: ☐ Basic Outpatient (<5 hours per week) ☐ Intensive Outpatient (5-20 hours per week)

☐ Psychiatry ☐ Long-term residential ☐ DUI/DWAI Related ☐ Individual Therapy

Admission Date	Facility	Treatment for (Diagnosis)	Type/Length of Treatment	Discharge Date

Current Over the Counter and Prescribed Medications:

Name of Medication	Dosage	Frequency

Current history of substance use:

Please submit to Peer Assistance Services 5 business days before your assessment date. Thank you.