

JEWISH FAMILY SERVICE OF THE LEHIGH VALLEY
(Please complete one form for each person requesting services)

Name: _____
Last First MI

Address: _____
Street Name City State Zip

Are you known by any other name: No Yes _____

Home Phone:(_____) _____ Work:(_____) _____

Contact Restrictions: home okay to ID caller from JFS no ID first name only
work okay to ID caller from JFS no ID first name only

Insurance Information (Medicare & Medigap #s) _____

Gender M / F Date of Birth: ____ / ____ / ____ Age: _____ Social Security # _____

Employer: _____ Occupation: _____

Employment Status: A. Full-time B. Part-time C. Armed Services
D. Sheltered Employment E. Unemployed F. Not in Labor Force G. School

Who referred you to our agency? _____ Phone (_____) _____

Primary Care Physician _____ Phone (_____) _____

Address _____

Medical concerns/allergies _____

Are you taking any medication? Yes No If yes, type and Reason _____

List All Medications Presently Being Taken _____

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Have you received services from Jewish Family Service in the past? No Yes

Have you or anyone in your family received counseling from any other agency? Yes No Where and when? _____

Marital Status A. Married B. Widowed C. Divorced D. Separated
E. Never Married F. Unknown

Emergency contact _____ Phone (_____) _____