EXCELSIOR

P: 509-559-3160 F:509-328-7582
E: admissions@excelsiorwellness.org
3754 W Indian Trail Rd, Spokane, WA 99208

Application for Services

DIRECTIONS:

- Email, Fax, or Mail this completed application ATTN: Admissions Coordinator.
- IF client is over 13, and is being referred by parent or other, an Authorization to Release Information Form must accompany this application.

Requested Services

☐ Psychiatric Services	☐ Outpatient Services	☐ Intensive Services	☐ Inpatient Services
• Assessments • Prescriptions • Medication Management	• Mental Health Counseling • SUD Counseling • WISe Program	• Intensive Outpatient • Intensive Inpatient	• LifePoint

Client Information

Last Name	First	Middle	Identified Gender ☐ Male ☐ Female
Date of Birth	Age	Social Security Number	

Address	Apt #	City	State	Zip

Contact Number	☐ Self ☐ Parent/Guardian ☐ Other: _____	Can we leave a voice message about your care? ☐ Yes ☐ No Email Address

Parent/Guardian (PRIMARY) Information

Last Name	First Name	MI	DOB

Relationship to Client	Physical Custody? ☐ Yes ☐ No	Legal Custody? ☐ Yes ☐ No	Emergency Contact? ☐ Yes ☐ No

Address	Apt #	City	State	Zip

Best Contact Number	☐ Cell ☐ Home ☐ Work ☐ Other? _____	Can we leave a voicemail? ☐ Yes ☐ No	Best Time to Call?
Alternate Contact Number	☐ Cell ☐ Home ☐ Work ☐ Other? _____	Can we leave a voicemail? ☐ Yes ☐ No	Best Time to Call?
Email Address:			

Client Insurance Information

Primary Insurance			Secondary Insurance		
Insurance Company Name			Insurance Company Name		
Policy Holder Name	Policy Holder DOB		Policy Holder Name	Policy Holder DOB	
Policy Holder SSN	Relationship to Patient		Policy Holder SSN	Relationship to Patient	
Group Name	Group No.	Identification No.	Group Name	Group No.	Identification No.
Policy Holder Address		Phone:	Policy Holder Address		Phone:

Client Referral Information

Reason for referral: Chief complaint and symptoms (please be specific including issues at home, work, or school as well as any symptoms noticed such as mood changes, etc.)

What are your specific goals with treatment services?

Client Medical Information		
Primary Care Provider	Phone Number	Approximate date of last physical:
Family Dentist	Phone Number	Approximate date of last dental exam:
Optometrist	Phone Number	Approximate date of last exam
Please list any medical aids (glasses/contacts, hearing aids, medical devices, orthodontia)		
Are you currently under the care of another provider? ☐ Yes ☐ No If Yes: Name and Address:		

Please list all prescription and/or over-the-counter medications currently being taken and the reasons for each (include prescriber name and phone number):

Medication	Dosage	Reason	Prescriber and Contact Number

Use an inhaler or epinephrine pen? ☐ Yes ☐ No

Please list name/type of inhaler/pen:

Describe any pertinent medical/physical information that might inhibit physical activity

Any dietary restrictions? ☐ Yes ☐ No

If yes, please describe (include any non-allergy related dietary requests/preferences):

Allergies/asthma: List all known allergies to medicines, food, insect bites/stings, etc.

Please include the severity of the reaction, how it was controlled and details/date of last reaction:

Is Client aware and in agreement with this referral for services. ☐ Yes ☐ No

Application completed by: _____

Relationship to Client: _____