CLIENT: _____
#: _____

Emergency Medical Information

(Please fill in all of the information. If something doesn't apply, write 'N/A'.)

Client Name: _____ **Phone #:** _____
Address: _____ **Email:** _____
_____

Medical Doctor's name: _____
Address: _____ **Phone #:** _____
_____

Psychiatrist's name: _____
Address: _____ **Phone #:** _____
_____

Emergency contact: _____ **Relationship:** _____
Address: _____ **Phone #:** _____
_____

Medical Insurance Company: _____ **Policy #:** _____

MEDICATION	DOSAGE

Allergies (Food/Medication):_____

Check the appropriate box:

YES	NO	
☐	☐	History of substance abuse
☐	☐	Significant Medical problems or conditions
☐	☐	Significant ambulatory or sensory problems
☐	☐	Significant communication problems

YES	NO	
☐	☐	Do you have any Limitations on accessing services (e.g., transportation, physical, and/or finances)?

YES	NO	
☐	☐	Do you have an Advance Medical Directive/ Living Will? If yes, then *attach copy*

Counseling Alliance of Virginia, LLC

2924 Emerywood Pkwy, Suite 200
Richmond, VA 23294
Office 804.346.5165
Fax 804.346.5167

callcava@cavaehelps.com

335 Greenbrier Dr. Suite 206
Charlottesville, Va. 22901
Office 434.220.0333
Fax: 434.220.0333

Revised 8/13/2021