



# Client General Information

**Instructions:** Please complete the entire form (print)

**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?** \_\_\_\_\_

**Mail or Fax Original To:**

**Metro Denver, Northern and Southern:**

Peer Assistance Services, Inc.  
2170 S. Parker Road, Suite 229  
Denver, CO 80231  
Phone: 303.369.0039 or 866.369.0039  
Fax: 720.213.1007

**Western Slope NURSE Clients Only:**

Peer Assistance Services, Inc.  
200 Grand Avenue, Suite 260  
Grand Junction, CO 81501  
Phone: 970.986.4360  
Fax: 970.241.9094



### Client General Information - Continued

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

**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:** \_\_\_\_\_

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## Client General Information - Continued

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

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 fax to Peer Assistance Services before your assessment date. Thank you.*

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