

**Adult Demographic Form**  
 Alaska Psychiatric Institute  
 Telebehavioral Healthcare Services  
*(Provider to Complete and Fax to 269-7129)*

Date:		Person Completing Form:		
Patient's Name: Last		First		Middle Initial
Maiden/Alias Name:		<input type="checkbox"/> Male <input type="checkbox"/> Female		Language Spoken at Home
Mailing Address: Street/PO Box			City	State ZIP
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Birth Date:	Birthplace:	U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No
Children: <input type="checkbox"/> Yes <input type="checkbox"/> No How many:		Name of Spouse:		Military: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Veteran <input type="checkbox"/> Active Duty
Race:				
<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Chinese	<input type="checkbox"/> Alaska Native	
<input type="checkbox"/> Black, African American	<input type="checkbox"/> Guamanian or Chamorro	<input type="checkbox"/> Filipino	<input type="checkbox"/> Aleut	<input type="checkbox"/> Tsimshian
<input type="checkbox"/> Hispanic, Latino, or Spanish Origin	<input type="checkbox"/> Somoan	<input type="checkbox"/> Japanese	<input type="checkbox"/> Eskimo	<input type="checkbox"/> Haida
<input type="checkbox"/> Mexican American	<input type="checkbox"/> Other Pacific Islander:	<input type="checkbox"/> Korean	<input type="checkbox"/> Alutiq	<input type="checkbox"/> Athabaskan
<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Yupik	<input type="checkbox"/> Tlingit
<input type="checkbox"/> Cuban	<input type="checkbox"/> American Indian	<input type="checkbox"/> Other:	<input type="checkbox"/> Inupiat	
Occupation:		Tribal Affiliation:		
Emergency Contact:		Employment Status:		
Patient's Clinic Site:		Emergency Contact Phone Number:		
Referred By:		Local Clinic Provider:		
Primary Health Care Provider :		Current Medical Conditions and Allergies:		
WHAT DO YOU WANT FROM THIS CONSULTATION? – Please be brief:				
REFERRAL CONCERNS RELEVANT TO THIS CONSULTATION – Please be brief:				
<b>Records to Attach</b>				
Most Recent Medical Exam by Primary Care Provider		Therapist Intake/Mental Health Evaluation (if available)		
Current Medication List		Treatment Plan (if available)		
Recent Emergency Room Visit Record if Applicable		Most Recent Progress Notes		