

**DESCRIPTION OF MENTAL EMOTIONAL, NERVOUS DISORDERS
OR CHEMICAL DEPENDENCY**

Name: _____
(Last) (First) (Middle)

SSN: _____

DATE OF TREATMENT: From: _____ To: _____

NAME OF TREATING PROFESSIONAL: _____

Street: _____

City: _____ State: _____ Zip _____

Telephone: _____

NAME OF HOSPITAL OR INSTITUTION: _____

Street: _____

City: _____ State: _____ Zip _____

Telephone: _____

Describe completely your diagnosis and treatment:

