

Behavioral Health Specialists, Inc.

CLIENT INFORMATION

PLEASE PRINT

Date: _____

Who completed this form? Client Other (name, relationship to client): _____
If other, please provide client's information for all questions.

First/Legal Name _____ Middle Initial _____ Last Name: _____

Previous Last Name/Maiden Name: _____ Male Female

Date of Birth: _____ Age: _____ Social Security Number: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone: _____

Cellular Phone: _____ Message Phone _____

Marital Status: Never married Cohabiting Married Divorced Separated Widowed

Employer: _____ Occupation: _____

Are you a Veteran? Yes No Are you a State Ward? Yes No

RACE American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or other Pacific Islander White Other (specify) _____

ETHNICITY Hispanic or Latino Not Hispanic or Latino

LANGUAGE English used? Yes No (if no, please specify) _____

DISABILITY Retardation Blindness Deafness Non-ambulation Non-use/amputation None

Referred by: _____ From: _____

County of Legal Residence: _____ County of Admission: _____

Please list everyone living in the your home (if private residence):

Name	Age	Sex	Relationship	Name	Age	Sex	Relationship
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Have you received services at Behavioral Health Specialists in the past? ___ Yes ___ No

Have you received services elsewhere in the past? ___ Yes ___ No If yes, where, when and with whom?

If you are a minor child of divorced parents, who has custody? Mother Father Other: _____

Do you have a Payee Conservator Legal Guardian Power of Attorney Not Applicable

If yes, what is that person's name and address? _____

EMERGENCY CONTACT Name _____ Day Phone _____

Relationship _____ Evening Phone _____

Legal Status: Describe your current and past history of legal involvement. If no legal history, check here

CLIENT: _____

DATE: _____

Insurance Information Please check all that apply

- None
- Private third party carrier
- Medicare
- Medicaid
- Blue Cross/Blue Shield
- HMO
- Employee Assistance
- Veterans Administration
- Workers Compensation
- Champus
- Other (specify) _____

Name of Insured (if other than client): _____

Relationship to Client: _____

Insured's Social Security Number: _____ Insured's Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone _____ Work Phone: _____

Insurance Company: _____ Phone Number: _____

Address: _____ Policy Number: _____

Group Number: _____ PPO: ___Yes ___No

Number of Dependents _____ (1 = self) Annual Gross Income (nearest \$1,000) _____

Supplemental Security Income (SSI)/Social Security Disability Income (SSDI):

- Eligible, receiving payments
- Potentially eligible
- Eligible, not receiving benefits
- Ineligible/Not applicable

Medicare

- Eligible, receiving payments
- Potentially eligible
- Eligible, not receiving benefits
- Ineligible/Not applicable

Medicaid

- Eligible, receiving payments
- Potentially eligible
- Eligible, not receiving benefits
- Ineligible/Not applicable

INCOME SOURCE Please check all that apply

- None
- Public Assistance
- Retirement/Pension
- Employment
- Disability
- Other (specify) _____

Medical Information: If female, are you pregnant? ___Yes ___No

Are you taking medication? ___Yes ___No If yes, please specify: _____

Are you allergic to any medication? ___Yes ___No If yes, please specify: _____

Physician: _____ Pharmacy: _____

Have you ever been hospitalized? ___Yes ___No If yes, where and when: _____

LIVING ARRANGEMENT Live alone Live with relative(s) Live with non-related person(s)

RESIDENTIAL ARRANGEMENT

- Private residence/household
- Regional Center
- Jail or correctional setting
- Child living with parent/relative
- Other psychiatric hospital
- Other therapeutic community
- Youth living independently
- Nursing facility
- Homeless
- Foster home
- Other residential

EDUCATION Number of years _____ (GED = 12)

EMPLOYMENT STATUS

- Employed full-time
- Employed part-time
- Active/Armed Forces
- Other (disabled, volunteer worker)
- Homemaker
- Retired
- Sheltered Workshop
- Student
- Supported Employment
- Unemployed/Looking
- Unemployed/Not Seeking

CLIENT: _____

DATE: _____

Please check all areas that are a concern or problem for you at this time.

EMOTIONAL HEALTH

- Getting too emotional
- Being verbally/emotionally abused
- Having the same thoughts over and over
- Having panic attacks
- Thoughts of harming self
- Thoughts of harming others

PHYSICAL HEALTH

- Concern about medical problem
- Concern that I weigh too much/too little
- Poor appetite
- Worried I have a sexually transmitted disease
- Worries about my pregnancy

SCHOOL

- Getting poor grades
- In trouble at school
- Miss a lot of school
- Don't get along with teachers

WORK

- Fired from job
- Don't get along with boss/co-workers
- Dissatisfied with my job

ALCOHOL/DRUGS/GAMBLING

- Using alcohol
- Using drugs
- Gambling
- Alcohol/drug use by family or friends
- Gambling a problem for family member or friend
- I'm in recovery but fear relapsing
- Family member is in recovery but near relapse

SOCIAL HEALTH

- Difficulty communicating with others
- Friends are a negative influence
- Legal problems
- Concern about family/friend in jail
- Lying
- Stealing
- Damaging property
- Physical aggression
- Running away

FAMILY LIFE

- Emotional reaction to divorce
- Children misbehaving
- Disagreeing on how to raise children
- Blended family (stepfamily) issues
- Being separated from spouse or family
- Strained relationship with parents
- Grieving loss of loved one

RELIGION

- Confused by religious beliefs
- Arguing about religion
- Cult involvement by self/family/friend
- Dissatisfied with my spiritual development

FINANCES

- Unpaid bills
- Bill collectors calling
- Owing money
- Budgeting money
- In or near bankruptcy
- Not enough money to pay rent or buy food

SEXUAL HEALTH

- Disliking sex
- Feeling used or pushed into sex
- Troubled by my or my partner's unusual sexual behavior
- Being gay

FOR CHILDREN ONLY

- Wetting your pants
- Soiling your pants
- Fire setting
- Carving/cutting/burning self
- Cruelty to animals
- Has nightmares
- Walks or talks in sleep
- Has difficulty getting to sleep
- Fears the dark
- Rocks, bangs head
- Wets the bed
- Sucks thumb
- Bites or picks nails
- Stutters or stammers
- Refuses to eat or eats too little
- Overeats
- Has inappropriate sex behavior
- Is disobedient, refuses to obey
- Withdraws, refuses to talk
- Has temper tantrums
- Is shy around strangers
- Shows off
- Is rude
- Is jealous
- Is selfish
- Runs away
- Is moody
- Demands too much attention
- Picks on other children
- Prefers older children
- Does dangerous things, tries to hurt self

CLIENT: _____

DATE: _____

Pain/Nutrition/Health/INFDIS Screen

PAIN SCREEN

Are you currently experiencing physical pain? Yes No

If yes, where is the pain located? _____

Please rate your level of pain on a scale of 1 to 10, with 1 being a very low level of pain and 10 being excruciating pain.

NUTRITION SCREEN

- I have an illness or condition that made me change the kind and/or amount of food I eat.
- I eat less than two meals per day.
- I eat few fruits, vegetables, or milk products.
- I have three or more drinks of beer/liquor/wine almost every day.
- I have tooth and/or mouth problems that make it hard for me to eat.
- I do not always have enough money to buy the food I need.
- I eat alone most of the time.
- I take three or more prescribed or over-the-counter drugs a day.
- Without wanting to, I have lost or gained 10 pounds in the last six months.
- I am not always physically able to shop, cook and/or feed myself.
- None of these statements apply to me.

HEALTH/INFECTIOUS DISEASE SCREEN

Do you (or any family members or past/present romantic partner) currently have, or ever had, any of the following:

<u>Self</u>	<u>Family Member</u>	<u>Partner</u>		<u>Self</u>	<u>Family Member</u>	<u>Partner</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	IV drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant currently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/COPD
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developmental delays
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia/Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis

Client Signature Date

- No referral necessary
 - Already under medical care
 - No acute or chronic health issues
- Appropriate referral made: _____

(identify provider/agency)

Interviewer comments: _____

Clinical Staff Signature Date