# 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 ☐ Cohabitating ☐ 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

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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:

| Self | Family Member | Partner | | Self | Family Member | Partner | |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | Tuberculosis | ☐ | ☐ | ☐ | Kidney disorder |
| ☐ | ☐ | ☐ | STD | ☐ | ☐ | ☐ | High blood pressure |
| ☐ | ☐ | ☐ | Hepatitis | ☐ | ☐ | ☐ | Allergies |
| ☐ | ☐ | ☐ | IV drug use | ☐ | ☐ | ☐ | Liver disorder |
| ☐ | ☐ | ☐ | Pregnant currently | ☐ | ☐ | ☐ | Diabetes |
| ☐ | ☐ | ☐ | Epilepsy | ☐ | ☐ | ☐ | HIV |
| ☐ | ☐ | ☐ | Heart disorder | ☐ | ☐ | ☐ | Emphysema/COPD |
| ☐ | ☐ | ☐ | Lung disorder | ☐ | ☐ | ☐ | Developmental delays |
| ☐ | ☐ | ☐ | Anemia/Sickle Cell Anemia | ☐ | ☐ | ☐ | 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