



Confidential Registration Data – Client Information

Please complete the following documents

[Please print and use a **blue or black pen** to fill out this form]

[Let us know if you need **special accommodations** to complete this application]

[Submit the application by mail, fax or bring it to our office **at least 24 hours before scheduling your intake consultation**].

[The application may be submitted by mail, fax, or in person]

PERSONAL INFORMATION

1. **First name**

2. **Last Name**

3. **M.I.**

4. **Today's Date**

Form completed by (if someone other than client)

5. **Date of Birth**

6. **Age**

7. **Social Security Number**

8. **Gender**

- Male Female
 Trans-Male Trans-Female
 Other Gender-Fluid

9. **Sexual Orientation**

- Heterosexual Lesbian
 Bisexual Questioning
 Gay Prefer not to answer

10. **Relationship Status**

- Single Married
 Separated Divorced
 Widowed Civil Union

11. **Ethnicity and Race Identification**

- African American/Black Hispanic
 Alaska Native/Native American Native Hawaiian/Pacific Islander
 Asian Multiracial
 Caucasian/White Other

12. **Birthplace**

13. **Spoken language (if other than English)**

CONTACT INFORMATION

14. **Current Home Address**

Apartment

City

State

Zip

15. **Mailing Address (if different from home address)**

Apartment

City

State

Zip

16. **Work Phone**

17. **Home Phone**

18. **Cell Phone**

Is it safe to reach you here? YES NO

May we leave a message? YES NO

Is it safe to reach you here? YES NO

May we leave a message? YES NO

Is it safe to reach you here? YES NO

May we leave a message? YES NO

19. **Email Address**

Please be aware that email might not be confidential.

Would you like to receive updates and appointment reminders using your email address?

EMERGENCY CONTACT

20. **Name**

21. **Relation to the client**

22. **Phone Number**

23. **Address**

Apartment

City

State

Zip

We may need your **written permission** to verbally discuss your protected health information with family members, legal guardians, or friends.

WHICH PROGRAM ARE YOU SEEKING SERVICES FROM?

Intensive Case Management (ICM)

Assertive Community Treatment (ACT)

Peer Support Services

Need help to decide



Sociodemographic Information

To be completed by the applicant

WHAT IS YOUR MILITARY STATUS?

- None Active or Standby Reserve
 Retired Military Active duty
 Vietnam Era Veteran Other Veteran
- If have been in services, have you seen combat activity? YES NO

LIVING ARRANGEMENT:

- Independent living (w/family) Inpatient facility Halfway house Residential facility
 Correctional facility Supported housing Residential treatment/group Homeless
 Nursing home Assisted Living Sober living Other residential facility

Do you expect this living arrangement to **change** during the next two weeks? *If you know the **exact date** of this change, write it in the space provided.*

YES NO

CURRENT PRIMARY ROLE:

- Employed (Full time) Student
 Employed (part time) Volunteer
 Unemployed Homemaker
 Retired Disabled
 Supported Employment Other

SPECIAL ACCOMODATOINS

- Traumatic Brain Injury Motor Disability/Epilepsy
 Speech and language disorders Severe emotional impairment
 Learning Disability Autism Spectrum Disorder
 Hearing impairment Other
 Visual Impairment None

EDUCATIONAL STATUS

- Please, select the highest grade you have completed:
- Grade 1 – 7 Grade 9 – 11 Some College College degree
 Grade 7 – 9 Grade 12 or GED Technical/Career Certification Master's or higher

FINANCIAL STATUS/SOURCES OF INCOME

What is your **total monthly income** \$

Do you receive SSI? YES NO
 Do you receive SSDI? YES NO

Do you receive any **other forms** of Government or State **support**? *(These may include food stamps or another form of financial assistance)*

LEGAL OR CRIMINAL JUSTICE SYSTEM INVOLVEMENT HISTORY

Is your interest in services prompted or suggested by the criminal justice system? YES NO Number of Arrests in **past 30** days

Are you on probation or parole, or awaiting charges, trial or sentence? YES NO

QUICK SELF-REPORT SCREENING QUESTIONS

ALCOHOL AND OTHER SUBSTANCE USE

In the past year, how often have you used the following?

In the spaces provided, write down the quantity *(for example, 4 drinks Daily)*

	Never	Occasionally	Monthly	Weekly	Daily
Alcohol					
Tobacco products					
Prescription drugs for non-medical reasons					
Non-prescription, recreational drugs					

CAGE-AID* QUESTIONNAIRE

- Have you ever felt that you ought to cut down on your drinking or drug use? YES NO
- Have people annoyed you by criticizing your drinking or drug use? YES NO
- Have you ever felt bad or guilty about your drinking or drug use? YES NO
- Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? YES NO



Insurance Information and Billing Authorization Form

To be completed by the applicant

PRIMARY INSURANCE

Insurance Name <input type="text"/>	Plan Type: <input type="text"/>	Plan Phone <input type="text"/>
Policyholder name (if other than the client) <input type="text"/>	Policyholder Date of Birth <input type="text"/>	Relation to the Applicant <input type="text"/>
Policy Number/Member ID <input type="text"/>	Employer/Group Number <input type="text"/>	Effective Date <input type="text"/>

SECONDARY INSURANCE

Insurance Name <input type="text"/>	Plan Type: <input type="text"/>	Plan Phone <input type="text"/>
Policyholder name (if other than the client) <input type="text"/>	Policyholder Date of Birth <input type="text"/>	Relation to the Applicant <input type="text"/>
Policy Number/Member ID <input type="text"/>	Employer/Group Number <input type="text"/>	Effective Date <input type="text"/>

ASSIGNMENT OF BENEFITS AND BILLING AUTHORIZATION

CHOICES, Inc. performs billing of Medicaid as a service. To agree to this service, read the following statement, place your initial next to each, then sign and date below:

Initials

I authorize CHOICES Inc. to directly bill Medicaid and other insurance on my behalf. Furthermore, I authorize Medicaid and other insurance to pay benefits on my behalf directly to CHOICES Inc. for items and services provided to me by CHOICES Inc.

I agree to notify CHOICES Inc. immediately of any changes in insurance coverage. I agree to pay all amounts owed to CHOICES Inc. that are not covered by Medicaid or other insurance, including applicable co-payments and deductibles for which I am responsible. I understand and agree that, regardless of my insurance status, I am ultimately responsible for understanding my insurance benefits and for the balance of my account.

I authorize any holder of medical or other information about me to release to CHOICES Inc. or its billing agent any information for this and any related health claim. Furthermore, I authorize CHOICES Inc. to release medical or other information about me for the purpose of obtaining payment from Medicaid or other insurance and their agents and assignees. Such records may be released to any individual or entity authorized to receive such information.

I agree to permit a fax or other copy of this form to serve as an original. Upon request, a copy of this form may be sent to Medicaid or other insurance and their agents or assignees. CHOICES Inc. will keep the original form on file. I understand that this authorization will remain in effect until revoked by me in writing.

SIGNATURE REQUIRED

Signature

Today's Date (mm/dd/yyyy)

If signed by someone other than the patient, I attest that I have the authority to sign on behalf of the patient



Presenting Problem and Personal History – Part I

To be completed by the applicant

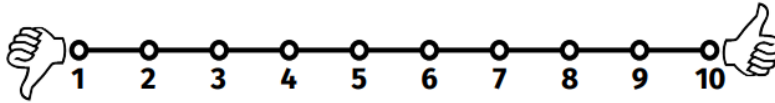
Following are questions regarding your personal history and the problems that brought you to us. The purpose of these questions is to gather initial background information in order to save time in your first session. Please feel free to skip questions that do not apply to you or that you are not comfortable answering. Please note that the more information you share, the more complete picture we will have of your situation. You will have an opportunity in your first session to provide more details and ask questions about this form.

PRESENT PROBLEM AND GOALS

List some of your reasons for seeking services with us or the changes you would like to make in your life.

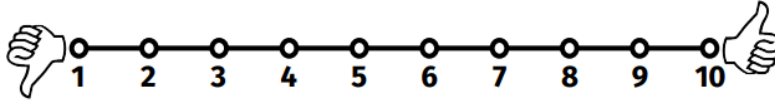
IMPORTANCE

On a scale of 1 to 10, with 1 meaning "not important at all", and 10 meaning "couldn't be more important," here's how important making these changes are to me:



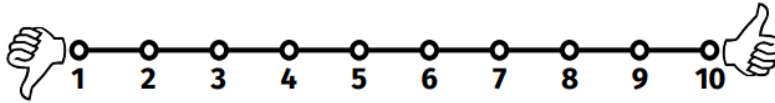
READINESS

On a scale of 1 to 10, with 1 meaning "not ready at all", and 10 meaning "couldn't be more ready," here's how ready I am to start making these changes:



CONFIDENCE

On a scale of 1 to 10, with 1 meaning "not confident at all", and 10 meaning "couldn't be more confident" here's how confident I am that I can make these changes:



IN THE PAST 6 MONTHS HOW MANY DAYS/TIMES WERE YOU TREATED AT OR ATTENDED...

1. Self-Help Program (AA, NA, ALANON, Etc.) in the past 30 days?
2. Inpatient, Residential or Hospital treatment for mental health problem? Substance use?
3. Been prescribed methadone, Suboxone or other type of medication assisted treatment for substance use problem?
4. Emergency Room for Mental Health problem? Substance use?

REFERRAL SOURCE

NOTE: If you are applying for ACT program, we require applicants to ask their care providers to submit a formal referral to us.

Person/Organization

Contact Information



Presenting Problem and Personal History – Part II

To be completed by the applicant

PLEASE ANSWER THE FOLLOWING QUESTIONS RELATED TO YOUR HEALTH:

During the past 12 months would you say your health in general was Very good Good Fair Poor

[If you are a female] Are you, or do you think you may be pregnant? Yes No I don't know
 Are you using any form of birth control? Yes No

	Never	0-12 Months	1-5 Years	5+ Years	Unknown
1. When was your last annual physical exam ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. When was your last dental appointment ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. When was your last flu shot ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. When have you been vaccinated against other illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. When was the last time, if ever, you were told that you have					
a. Hepatitis , yellow jaundice, or cirrhosis of the liver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Tuberculosis or TB?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Sexually transmitted diseases or infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Been tested for these or other infectious diseases or illnesses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you used or shared a needle to inject drugs ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had a severe head injury ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

Medication	Dosage	How often do you take it?	Any side effects?

PLEASE LIST ANY KNOWN CHRONIC HEALTH, MENTAL HEALTH CONDITIONS OR ALLERGIES:

Condition	Are you currently receiving treatment for it?		Family history of this condition		
	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Don't Know
	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Don't Know
	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Don't Know
	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Don't Know
	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Don't Know
	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Don't Know
	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Don't Know

*If more space is needed, attach additional page

WHO IS YOUR PRIMARY CARE PHYSICIAN (PCP)

Check here if you do not have a PCP

Name of Primary Care Office

Name of a Primary Care Provider

Phone Number of Primary Care Office:

How long have you been cared for by this provider?



Additional Screening Questions

To be completed by the applicant

DSM-5 SELF-RATED CROSS-CUTTING SYMPTOM MEASURE

The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

During the past TWO (2) WEEKS , how much (or how often) have you been bothered by the following problems?		None Not at all	Slightly Rarely	Mild Less than 7 days	Moderate 7 days or more	Severe Nearly every day
I	1. Little interest or pleasure in doing things?	0	1	2	3	4
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4
II	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4
	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4
III	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4
	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4
IV	7. Feeling panic or being frightened?	0	1	2	3	4
	8. Avoiding situations that make you anxious?	0	1	2	3	4
V	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4
VI	11. Thoughts of actually hurting yourself.	0	1	2	3	4
	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4
VII	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4
	14. Problems with sleep that affected your sleep quality overall.	0	1	2	3	4
IX	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4
	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4
X	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4
	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4
XI	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4
	20. Not feeling close to other people or enjoying your relationships with them	0	1	2	3	4
XIII	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed?	0	1	2	3	4

TRAUMATIC EVENTS

Sometimes things happen to people that are unusually or especially **frightening, horrible, or traumatic**. *Have you experienced any of these?*

- | | |
|--|--|
| <input type="checkbox"/> Serious, life threatening illness | <input type="checkbox"/> Military Combat or lived in a war zone |
| <input type="checkbox"/> Physical Assault | <input type="checkbox"/> Child Abuse |
| <input type="checkbox"/> Sexual Assault | <input type="checkbox"/> Accident (serious injury or death of a loved one) |
| <input type="checkbox"/> Natural Disaster | <input type="checkbox"/> Other trauma |

If you checked any of the above events, which traumatic experience is on your mind and currently bothers you the most: