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
- ☐ Alaska Native/Native American
- ☐ Asian
- ☐ Caucasian/White
- ☐ Hispanic
- ☐ Native Hawaiian/Pacific Islander
- ☐ Multiracial
- ☐ 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
- ☐ Retired Military
- ☐ Vietnam Era Veteran
- ☐ Active or Standby Reserve
- ☐ Active duty
- ☐ Other Veteran

If have been in services, have you seen combat activity? ☐ YES ☐ NO

LIVING ARRANGEMENT:

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

*Do you expect this living arrangement to **change** during the next two weeks?*
☐ YES ☐ NO

*If you know the **exact date** of this change, write it in the space provided.*

CURRENT PRIMARY ROLE:

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

SPECIAL ACCOMODATOINS

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

EDUCATIONAL STATUS

Please, select the highest grade you have completed:

- ☐ Grade 1 – 7
- ☐ Grade 7 – 9
- ☐ Grade 9 – 11
- ☐ Grade 12 or GED
- ☐ Some College
- ☐ Technical/Career Certification
- ☐ College degree
- ☐ 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

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

Number of Arrests in ***past 30*** days

QUICK SELF-REPORT SCREENING QUESTIONS

ALCOHOL AND OTHER SUBSTANCE USE

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

In the past year, how often have you used the following?	**Never**	**Occasionally**	**Monthly**	**Weekly**	**Daily**
Alcohol					
Tobacco products					
Prescription drugs for non-medical reasons					
Non-prescription, recreational drugs					

CAGE-AID* QUESTIONNAIRE

1. Have you ever felt that you ought to cut down on your drinking or drug use? ☐ YES ☐ NO
2. Have people annoyed you by criticizing your drinking or drug use? ☐ YES ☐ NO
3. Have you ever felt bad or guilty about your drinking or drug use? ☐ YES ☐ NO
4. 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	Plan Type:	Plan Phone
Policyholder name (if other than the client)	**Policyholder Date of Birth**	**Relation to the Applicant**
Policy Number/Member ID	**Employer/Group Number**	**Effective Date**

SECONDARY INSURANCE

Insurance Name	Plan Type:	Plan Phone
Policyholder name (if other than the client)	**Policyholder Date of Birth**	**Relation to the Applicant**
Policy Number/Member ID	**Employer/Group Number**	**Effective Date**

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

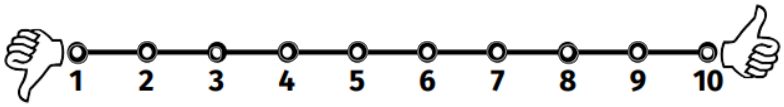
Following are questions regarding your personal history and the problems that brought you to us. The purpose of these questions is to gather initial background information in order to save time in your first session. Please feel free to skip questions that do not apply to you or that you are not comfortable 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.

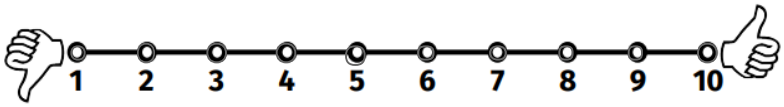
Importance

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:



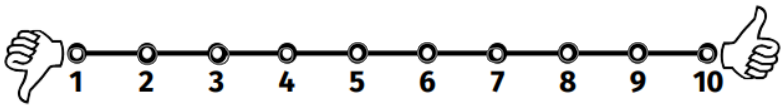
Readiness

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**?	☐	☐	☐	☐	☐
2.	When was your last **dental appointment**?	☐	☐	☐	☐	☐
3.	When was your last **flu shot**?	☐	☐	☐	☐	☐
4.	When have you been **vaccinated** against other illnesses?	☐	☐	☐	☐	☐
5.	When was the last time, if ever, you were told that you have					
	a. **Hepatitis**, yellow jaundice, or cirrhosis of the liver?	☐	☐	☐	☐	☐
	b. **Tuberculosis** or TB?	☐	☐	☐	☐	☐
	c. **Sexually transmitted diseases or infections**	☐	☐	☐	☐	☐
	d. Been **tested** for these or other **infectious diseases** or illnesses	☐	☐	☐	☐	☐
6.	Have you used or shared **a needle to inject drugs?**	☐	☐	☐	☐	☐
7.	Have you ever had a severe **head injury**?	☐	☐	☐	☐	☐

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*		
	☐ YES	☐ NO	☐ YES	☐ NO	☐ Don't Know
	☐ YES	☐ NO	☐ YES	☐ NO	☐ Don't Know
	☐ YES	☐ NO	☐ YES	☐ NO	☐ Don't Know
	☐ YES	☐ NO	☐ YES	☐ NO	☐ Don't Know
	☐ YES	☐ NO	☐ YES	☐ NO	☐ Don't Know
	☐ YES	☐ NO	☐ YES	☐ NO	☐ Don't Know
	☐ YES	☐ NO	☐ YES	☐ NO	☐ 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?

CHOICES
Consumers Having Ownership in Creating Effective Services

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
III	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4
IV	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4
	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
VII	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4
VIII	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
X	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4
XI	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4
XII	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?*

- ☐ Serious, life threatening illness
- ☐ Physical Assault
- ☐ Sexual Assault
- ☐ Natural Disaster
- ☐ Military Combat or lived in a war zone
- ☐ Child Abuse
- ☐ Accident (serious injury or death of a loved one)
- ☐ Other trauma

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