Name:_____Date of Birth_____

Aliases/preferred name_____

Social Security Number: _____

Address_____

Phone:_____

Email: _____

Preference for receiving appointment reminders (choose one) Text ____ Email ____ Voice mail message _____

Insurance Information:

Insurance Carrier: _____

Policy Holder Name: _____ DOB: _____

ID#_____ GRP#_____

Carrier Phone Number: _____

Carrier Address: _____

General

Sex at Birth: Male Female

Do you identify with LGBTQ+ community? Prefer not to answer NO YES (orientation)_____

Gender Identity/Preferred pronouns (if different from birth)_____

Do you have any disabling conditions? NO YES (list)_____

1. Race: Black/African American American Indian/Native Alaskan Asian White Native Hawaiian/Pacific Islander
   Multi Racial Prefer not to answer.
2. Ethnicity: Not Hispanic Puerto Rican Mexican Cuban Other Hispanic
3. Are you receiving food stamps/SNAP? NO YES Are you receiving TANF? NO YES
4. What is the highest level of education you completed? _____
   Do you have any barriers or challenges to learning or reading? NO YES_____
5. Are you currently employed? NO, but seeking NO disabled/retired NO Homemaker
   YES -Full time YES part time _____hrs per week.
6. Have you ever served in any branch of armed forces NO YES
   a. If yes, Have you ever been deployed? NO YES
   b. Have you served in Combat? NO YES
   c. Are you a Veteran? NO YES

7. Has any member of your immediate family served in any branch of the armed forces/military? NO YES
8. Support groups you are attending: NONE or
   (List)_____
9. # of HOUSEHOLD MEMBERS (you are financially responsible for) _____ Annual Income $ _____
10. Do you have a family doctor or primary care provider? NO YES
    (who)_____
11. Are you currently taking medications? NO YES (list below)
    MEDS_____
    _____
12. Check any HEALTH ISSUES that apply to You -

    Diabetes ☐ cardiovascular disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Cancer ☐

    Smoking ☐ Obesity☐ Asthma☐

    HEP A ☐ HEP B ☐ HEP C ☐ TB ☐ HIV/AIDS☐

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13. Have you ever been to counseling or been hospitalized for mental health/substance use treatment? No Yes (where, when and diagnosis if other than CMHC)

    _____

    _____

14. If you were referred to services by someone please identify who… _____

Additional comments:

SUBSTANCE Use

Primary_____Route:_____Age of First use:_____

Date of last use:_____ Frequency prior to last use:_____

Secondary_____Route:_____Age of First use:_____

Date of last use:_____ Frequency prior to last use:_____

Tertiary_____Route:_____Age of First use:_____

Date of last use:_____ Frequency prior to last use:_____

.Are you a tobacco user? NO YES Previous user

Have you ever used a needle to ingest substances? NO YES, Shared Needles YES, Clean needles

UNCOPE

Have you continued to use alcohol or drugs longer than you intended? NO YES

Have you ever neglected some of your usual responsibilities because of alcohol or drug use? NO YES

Have you ever wanted to cut down or stop using alcohol or drugs but couldn't? NO YES

Has your family, a friend or anyone else ever told you they objected to your alcohol or drug use? NO YES

Have you ever found yourself preoccupied with wanted to use alcohol or drugs? NO YES

Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom? NO YES

Substance Abuse Symptoms/Consequences

Odor of substance☐ Slurred Speech☐ Withdrawal Symptoms☐ Increased tolerance☐

Blackouts☐ Loss of Control☐ Related Social Problems☐ Frequent Job/School Absence☐

DUI/DWI How many in last 30 days?_____ How many in last 5 years?_____

Possession How many in last 30 days?_____ How many in last 5 years?_____