NEW CLIENT ENROLLMENT: **DEMOGRAPHIC INFORMATION**

Please let a front desk staff person know if you would like help filling out this form.

Name (first, middle, last):		Today's Date (mm/dd/yyyy):
Preferred Name:	Alternate Last Name:	
Address:	Email:	Phone Number:

Accessibility Accommodations	
Primary Language: Secondary Language: Preferred Language:	Do you need an interpreter? / ¿Necesita un intérprete? ❑ Yes / Si ❑ No / No
Hearing Do you need accommodations for your hearing? ❑ Yes. Please Describe: ❑ No	**Sight** Do you need accommodations for your sight? ❑ Yes. Please Describe: ❑ No

Demographic Information	
Birthday (mm/dd/yyyy):	Social Security Number (xxx-xx-xxxx):

NEW CLIENT ENROLLMENT: **DEMOGRAPHIC INFORMATION**

Pronouns: ❑ She/Her ❑ He/Him ❑ They/Them ❑ Something Else, Please Describe:	Birth Sex: ❑ Male ❑ Female	Sexual Orientation: ❑ Lesbian, Gay, or Homosexual ❑ Straight or Heterosexual ❑ Bisexual ❑ Something Else, Please Describe: ❑ Don't Know ❑ Choose Not to Disclose	Gender Identity: ❑ Identifies as Male ❑ Identifies as Female ❑ Female-to-Male (FTM/Transgender Male/Trans Man ❑ Male-to-Female (MTF)/Transgender Female/Trans Woman ❑ Genderqueer, neither exclusively male or female ❑ Additional Gender category or other, please specify: ❑ Choose Not to Disclose
Race: ❑ Alaska Native ❑ Asian ❑ Black/African American ❑ Choose not to disclose ❑ Native American ❑ Native Hawaiian/Other Pacific Islander ❑ Other Single Race ❑ Two or More Races ❑ Unknown ❑ White	Ethnicity: ❑ Cuban ❑ Mexican ❑ Puerto Rican ❑ Hispanic – specific origin not specified ❑ Not Hispanic ❑ Unknown	Living Status: ❑ Private Residence - Adult (Own home or other's home) ❑ Private Residence - Child ❑ Community Residence (Ex: ADAMHS Board Housing, Recovery Housing) ❑ Correctional Facility ❑ Foster Care ❑ Homeless ❑ Permanent Supportive Housing ❑ Residential Care/Group Home/ACF (Ex: Assisted Living, Nursing Home, other supervised congregate living for adults or children) ❑ DD Licensed/Operated Facility ❑ Temporary Housing (Ex: Transitional Housing, Respite, Crisis Care) ❑ Other: ❑ Unknown	Marital Status: ❑ Divorced ❑ Married/Living with Partner ❑ Separated ❑ Single ❑ Unknown ❑ Widowed

NEW CLIENT ENROLLMENT: **DEMOGRAPHIC INFORMATION**

Tobacco Use

Tobacco Use (Includes cigarettes, smokeless tobacco, vaping, etc.):

❑ Current User ❑ Non-User ❑ Choose not to disclose

Type of Tobacco Use:

❑ Light (1-9 cigs/day) ❑ Moderate (10-19 cigs/day) ❑ Heavy (20-39 cigs/day) ❑ Very Heavy (40+ cigs/day) ❑ Chews Tobacco ❑ Pipe Smoker ❑ Choose not to disclose

Smoking Status:

❑ Current Smoker ❑ Former Smoker ❑ Never Smoked ❑ Choose not to disclose

Guardianship

❑ Adult ❑ Adult with Guardian ❑ Minor ❑ Minor with Guardian who is not a Parent ❑ Minor without Consent

Military Status

❑ None ❑ Active Duty ❑ Disabled Veteran (Disability resulting from military service, may also be discharged) ❑ Discharged

Employment Information

Employment Status:

❑ Full-Time
❑ Part-Time
❑ Sheltered Employment
❑ Unemployed
❑ Homemaker
❑ Student
❑ Volunteer Worker
❑ Retired
❑ Disabled
❑ Inmate of Jail/Prison/Corrections
❑ Engaged in Residential/Hospitalization
❑ Other not in Labor Force
❑ Unknown
❑ Self-Employed

Occupation:

Job Title:

Days Worked in the Past 30 Days:

NEW CLIENT ENROLLMENT: **DEMOGRAPHIC INFORMATION**

Education Information

Education Status:
Please indicate the highest grade or degree you/the client has completed so far.

- ❑ Kindergarten
- ❑ Less than 1 grade completed
- ❑ 1st Grade
- ❑ 2nd Grade
- ❑ 3rd Grade
- ❑ 4th Grade
- ❑ 5th Grade
- ❑ 6th Grade
- ❑ 7th Grade
- ❑ 8th Grade
- ❑ 9th Grade
- ❑ 10th Grade
- ❑ 11th Grade
- ❑ 12th Grade
- ❑ High School Diploma/GED
- ❑ Trade/Technical School
- ❑ Associate's Degree
- ❑ Undergraduate Degree
- ❑ Master's Degree
- ❑ Doctorate Degree
- ❑ Other Professional Degree

Education Type:
Please indicate the current education type you/the client are enrolled in.

- ❑ Not Enrolled in School
- ❑ Currently Attending Pre-School
- ❑ Currently Attending GED School
- ❑ Currently Attending K-12th Grade
- ❑ Currently Attending Vocational Job Training
- ❑ Currently Attending College
- ❑ Currently Attending Other School (i.e. Adult Basic Education, Literacy)
- ❑ Unknown
- ❑ Not Attending in Last 3 Months

If currently enrolled in school, which school do you/the client currently attend?

Do you/the client have an IEP (Individual Education Plan)? ❑ Yes ❑ No

If you/the client is currently enrolled in vocational job training, please indicate how long you/the client has been enrolled:

❑ 6 months ❑ 30 days ❑ Not Applicable

Referral Source

- ❑ AOD Care Provider
- ❑ Child Welfare Agency (i.e. CDJFS, CSBS)
- ❑ Courts/Other Criminal Justice (i.e. court, probation, parole, diversion programs)
- ❑ Employer/EAP
- ❑ Individual (self-referral, family, friend)
- ❑ Mental Health Treatment Provider (i.e. Clinic, Hospital, or other Health Care Provider who primarily treats mental illness)
- ❑ IMPACT - Shelby County
- ❑ QRT (Quick Response Team) - Hancock County
- ❑ School
- ❑ Other Community Referral:
- ❑ Other Health Provider (i.e. Nursing Home, Medical Clinic, VA, Primary Care Provider, Health Department)
- ❑ Ohio Family and Children First Council (FCFC)
- ❑ State Psychiatric Hospital
- ❑ State Prison
- ❑ Jail
- ❑ Unknown

NEW CLIENT ENROLLMENT: **DEMOGRAPHIC INFORMATION**

Household Information

Annual Household Income: $

Number of Individuals in your Household:

Number of Individuals under 18 in your Household:

Total Number of Dependents:

Sources of Income (check all that apply):

❑ Disability

❑ Family/Relative

❑ None

❑ Other

❑ Public Assistance

❑ Retirement/Pension

❑ Wages/Salary Income

Which Source of Income is your Primary Source?

Emergency Contacts

First and Last Name:

Relationship to Client:

Phone Number:

First and Last Name:

Relationship to Client:

Phone Number:

NEW CLIENT ENROLLMENT: **DEMOGRAPHIC INFORMATION**

Guarantor Information

Name:	Phone:	Address:

Guarantor's Relationship to the Client:

❑ Adopted Child ❑ Child ❑ Employer ❑ Grandparent ❑ Payee
❑ Aunt/Uncle ❑ Parent ❑ Foster Child ❑ Grandchild ❑ Self
❑ Sibling ❑ Employee ❑ Foster Parent ❑ Nephew/Niece ❑ Other:

I am the Legal Guardian of the Client ❑ Yes ❑ No

I am the Contact for Appointments for the Client ❑ Yes ❑ No

I am the recipient of statements for the Client ❑ Yes ❑ No

I am the Client and am paying for myself ❑ Yes ❑ No

Insurance Information

Please check or write in the insurance/payer source that describes your plan:

❑ Self-Pay ❑ Private ❑ Medicaid ❑ Medicare ❑ EAP/Workplace Advantage - Please write company name:
❑ Something else:

Primary Insurance/Payer:		
Subscriber Name:	Subscriber Social Security #:	Subscriber DOB:
Member/Subscriber ID #:		Group Number:
Secondary Insurance/Payer if applicable:		
Subscriber Name:	Subscriber Social Security #:	Subscriber DOB:
Member/Subscriber ID #:		Group Number:

Signature

With my signature below, I am acknowledging that the information I have provided is accurate and true to the best of my ability.

First and Last Name (Please Print) _____ Relationship to Client _____

Your Signature _____ Today's Date _____

NEW CLIENT ENROLLMENT: **HEALTH HISTORY QUESTIONNAIRE**

Please let a front desk staff person know if you would like help filling out this form.

Name (First, Middle, Last):	DOB:	Today's Date:

Health Problem	Now	Past	If you received treatment for this problem, please write treatment and dates.
Anemia			
Arthritis			
Asthma			
Bleeding Disorder			
Blood Pressure (High or Low)			
Bone/Joint Problems			
Cancer			
Cirrhosis/Liver Disease			
Diabetes			
Epilepsy/Seizures			
Eye Disease/Blindness			
Fibromyalgia/Muscle Pain			
Glaucoma			
Headaches			
Head Injury/Brain Tumor			
Hearing Problems/Deafness			
Heart Disease			
Hepatitis/Jaundice			
Kidney Disease			
Lung Disease			
Menstrual Pain			
Oral Health/Dental Problems			
Stomach/Bowel Problems			
Stroke			

NEW CLIENT ENROLLMENT: **HEALTH HISTORY QUESTIONNAIRE**

Health Problem	Now	Past	If you received treatment for this problem, please write treatment and dates.
Thyroid			
Tuberculous			
Aids/HIV			
Sexually Transmitted Disease			
Learning Problems			
Speech Problems			
Anxiety			
Bipolar Disorder			
Depression			
Eating Disorder			
Hyperactivity/ADD			
Schizophrenia			
Sexual Problems			
Sleep Disorder			
Suicide Attempt/Thoughts			
Other:			

Family Health History

Are you aware of any family history related to any of the health problems listed on pages 1 & 2?

❏ Not Applicable (Adopted/Unknown)

Health Problem/Condition:	Family Member(s):

Allergies/Drug Sensitivities

❏ None ❏ Food ❏ Medicine ❏ Other	If yes, please specify:

NEW CLIENT ENROLLMENT: **HEALTH HISTORY QUESTIONNAIRE**

Current Medications					
Prescribed Medications	Dosage (mg, unit, etc.)	Route (mouth, injection, etc.)	Frequency (how often)	Date Prescribed	Prescribing Physician
Over-the-Counter Medications	Dosage (mg, unit, etc.)	Route (mouth, injection, etc.)	Frequency (how often)	Begin Date	End Date

Hospitalization/Surgery			
Have you/the client been hospitalized or had any surgical procedures in the last three (3) years? If yes, please describe below. ❑ Yes ❑ No			
Hospital	**City**	**Date**	**Reason**

NEW CLIENT ENROLLMENT: **HEALTH HISTORY QUESTIONNAIRE**

Pregnancy History			
Are you currently pregnant?	❑ Yes	❑ No	If yes, please complete the fields below.
Are you receiving prenatal healthcare?	❑ Yes	❑ No	Expected delivery date:
Are you currently breastfeeding?	❑ Yes	❑ No	Last menstrual period date:
Do you have a history of any pregnancy complications?	❑ Yes	❑ No	If yes, please describe in the space below.

Primary Care Physician (PCP)/Family Doctor	
Do you have a PCP/Family Doctor? ❑ Yes ❑ No	
PCP/Family Doctor:	
Address:	Phone:

Last Physical Examination
When was your last physical exam?
Physician:
Phone:

Symptoms

Have you experienced any of the following symptoms in the past two (2) months?

- ❑ None
- ❑ Ankle Swelling
- ❑ Bed Wetting
- ❑ Blood in Stool
- ❑ Breathing Difficulty
- ❑ Chest Pain
- ❑ Confusion
- ❑ Consciousness Loss
- ❑ Constipation
- ❑ Coughing
- ❑ Cramps
- ❑ Diarrhea
- ❑ Dizziness
- ❑ Gait Unsteadiness
- ❑ Hair Change
- ❑ Lightheadedness
- ❑ Memory Problems
- ❑ Mole/Wart Changes
- ❑ Muscle Weakness
- ❑ Nervousness
- ❑ Nosebleeds
- ❑ Numbness
- ❑ Other
- ❑ Panic Attacks
- ❑ Penile Discharge
- ❑ Pulse Irregularity
- ❑ Seizures
- ❑ Shakiness
- ❑ Sleep Problems
- ❑ Sweats (night)
- ❑ Tingling in Arms and Legs
- ❑ Urination Difficulty
- ❑ Vaginal Discharge
- ❑ Vision Changes
- ❑ Vomiting

Have you experienced any of the above symptoms in the past six (6) months?	Have you been treated for these symptoms?
❑ Yes ❑ No	❑ Yes ❑ No

NEW CLIENT ENROLLMENT: **HEALTH HISTORY QUESTIONNAIRE**

Immunizations

Is the Client a child or diagnosed with a developmental disability? ❑ Yes ❑ No

If yes, please check whether or not the Client has been immunized for the following diseases:

❑ Mumps	❑ Chicken Pox	❑ Hepatitis B	❑ Other
❑ Polio	❑ Diphtheria	❑ Tetanus	
❑ Smallpox	❑ German Measles	❑ Measles	

Immunizations in the past year:

Height and Weight

Height:	Has your weight changed in the past year?	If yes, by how much? (lost of gained):
Weight:	❑ Yes ❑ No	

Nutritional Information

Eating:	Drinking Fluids:	Appetite:	Are you on a specific diet? If so, please describe:
❑ More	❑ More	❑ Increased appetite	
❑ Less	❑ Less	❑ Decreased appetite	
❑ Not eating	❑ Liquid-only diet	❑ Nausea	
❑ No problems	❑ No problems	❑ Vomiting	
		❑ Trouble chewing or swallowing	
		❑ No problems	

Is there any other nutritional information you would like us to know?

NEW CLIENT ENROLLMENT: **HEALTH HISTORY QUESTIONNAIRE**

Pain Screening
Does pain currently interfere with your daily activities? ❑ Yes ❑ No
If yes, how much does it interfere with your daily activities? ❑ Mildly ❑ Severely ❑ Moderately ❑ Extremely
Please describe:

Caffeine Use
Do you use caffeine? ❑ Yes ❑ No
If yes, indicate the form and frequency (i.e. 2 cups of coffee/day):

Tobacco Use
Do you use tobacco? ❑ Yes ❑ No
If yes, indicate the form and how much per week (i.e. 5-10 cigs/day):

Substance Use Screening				**If applicable, describe use:**
Alcohol/Beer/Wine	❑ No	❑ Past	❑ Current	
Marijuana	❑ No	❑ Past	❑ Current	
Hashish	❑ No	❑ Past	❑ Current	
Stimulants	❑ No	❑ Past	❑ Current	
Sleep Medication	❑ No	❑ Past	❑ Current	
Tranquilizers	❑ No	❑ Past	❑ Current	
Hallucinogens	❑ No	❑ Past	❑ Current	
Inhalants	❑ No	❑ Past	❑ Current	
Cocaine/Crack	❑ No	❑ Past	❑ Current	
Heroin	❑ No	❑ Past	❑ Current	
Pain Medication	❑ No	❑ Past	❑ Current	
Other:	❑ No	❑ Past	❑ Current	