TODAY'S DATE: _____ Chart # _____

Request for Services

APPLICANT NAME: _____ GENDER: ☐ FEMALE ☐ MALE
LAST, FIRST, MIDDLE NAME (MAIDEN, IF APPLICABLE)

ADDRESS / CITY / STATE / ZIP: _____

DATE OF BIRTH: _____AGE: _____ PHONE:_____ Soc. Sec. #: _____

ALTERNATE NUMBER: _____ HOW DO YOU PREFER WE GET IN TOUCH WITH YOU? (INCLUDE EMAIL HERE, IF APPLICABLE): _____

EMERGENCY CONTACT NAME AND NUMBER: _____

RELATIONSHIP TO CLIENT: _____ SOURCE / PROVIDER OF INFORMATION: _____

DO YOU HAVE A LEGAL GUARDIAN / CUSTODIAN? IF SO, PLEASE INCLUDE NAME AND NUMBER: _____
_____

ARE YOU CURRENTLY, OR HAVE YOU EVER, RECEIVED SERVICES FOR A MENTAL HEALTH OR SUBSTANCE USE CONCERN? ☐ NO ☐ YES
IF YES, WHERE AND APPROXIMATELY WHEN? UNDER WHAT NAME? _____

WHEN WAS YOUR LAST TB TEST?_____ ARE YOU HIV+? ☐YES ☐NO ☐PREFER NOT TO ANSWER
HAVE YOU EVER HAD A TB SKIN TEST COME BACK POSITIVE? ☐YES ☐NO IF YES, WHEN?_____
HAVE YOU WORKED IN HEALTH CARE, OR STAYED N A HOMELESS SHELTER, JAIL, OR PRISON FOR MORE THAN 8 HOURS AT A TIME IN THE PAST YEAR? ☐YES ☐NO
HAVE YOU LIVED WITH OR SPENT MORE THAN 8 HOURS AT A TIME WITH SOMEONE WHO YOU KNEW WAS SICK FROM TB?
☐YES ☐NO
WHERE WERE YOU BORN?_____

HOW CAN WE HELP YOU TODAY? (IMMEDIATE CLINICAL CARE NEEDS RELATED TO MENTAL HEALTH AND/OR SUBSTANCE USE CONCERNS):_____
_____

ARE YOU CURRENTLY HAVING THOUGHTS OF HARMING YOURSELF OR ANYONE ELSE?	☐ **NO**	☐ **YES**
DO YOU HAVE ANY CONCERNS FOR YOUR SAFETY?	☐ **NO**	☐ **YES**
ARE YOU SEEKING RESIDENTIAL TREATMENT SERVICES FOR SUBSTANCE ABUSE?	☐ **NO**	☐ **YES**

ANNUAL HOUSEHOLD INCOME: _____ # IN HOUSEHOLD? _____

SOURCE(S) OF INCOME: (CHECK ALL THAT APPLY) ☐ EMPLOYMENT ☐ SSI ☐ SSDI ☐ FOOD STAMPS ☐ TANF
☐ OTHER: _____

DO YOU HAVE HEALTH INSURANCE? ☐ NO ☐ YES - IF YES, WITH WHOM AND INCLUDE YOUR ID NUMBER: _____
_____

RACE (CHECK ALL THAT APPLY): ☐ AMERICAN INDIAN ☐ BLACK / AFRICAN AMERICAN ☐ ASIAN ☐ WHITE
☐ NATIVE HAWAIIAN/PACIFIC ISLANDER
ETHNICITY: _____PREFERRED LANGUAGE: ☐ ENGLISH ☐ OTHER _____
OTHER LANGUAGES SPOKEN: _____
WHO REFERRED YOU HERE TODAY? ☐ MYSELF ☐ OTHER _____
IF REFERRED BY THE COURT / CRIMINAL JUSTICE SYSTEM, WHAT COUNTY WERE THE LEGAL PROCEEDINGS HELD? _____
_____

ARE YOU CURRENTLY HOMELESS? ☐ NO ☐ YES IF YES, HOW LONG HAVE YOU BEEN HOMELESS? _____
HAVE YOU BEEN HOMELESS AT ANY TIME DURING THE PAST THREE (3) YEARS? ☐ NO ☐ YES IF YES, HOW MANY TIMES? _____
DO YOU NEED ANY SPECIAL HELP OR EQUIPMENT TO ACCESS SERVICES? ☐ NO ☐ YES -IF YES, WHAT? _____
Marital Status of Person requesting services: ☐Single ☐Married ☐Divorced ☐ Separated
Do you use tobacco products (including e-cigarettes, vaping)? If yes, how many times per day? _____
Have you ever served in the military? ☐YES ☐NO If yes - when, type and status: _____
Has a member of your family served in the military? ☐YES ☐NO If yes, who and which branch? _____

PATIENT HEALTH QUESTIONNAIRE – 9

(PHQ-9) (To be completed by Adults and children over 12 years of age).

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Circle the appropriate response)*	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you circled <u>any</u> problems above, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or take care of other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Name:_____ Chart #:_____