

WELCOME

We are here to help

To better assist you, we ask that you please answer the following questions along with the other questionnaires in this packet. If you need assistance, please ask the receptionist staff or the staff member that you meet with for the screening

Client Name: _____ Client Date of Birth : _____

Have you received a DUI/DWI in the past 6 months? Yes No

- If **YES to the question above**, please inform the front desk and discontinue completing this form.
- If **NO to the question above**, please continue answering the questions below.

Are you looking for Methadone treatment? Yes _____ No _____. If you are receiving services in Clinton, Warsaw, Warrensburg, Higginsville, or Sedalia, you may be eligible for Opiod Treatment services.

DEMOGRAPHIC INFORMATION

Homeless Indicator: Not Homeless In Homeless Shelter On the Streets

Client Address: _____ City, State, Zip : _____

County: : _____ Client Home Number: _____

Client Cell Phone: _____ Client Email Address : _____

Client Social Security Number: _____

Sex (Assigned at Birth):	<input type="checkbox"/> Female	<input type="checkbox"/> Male
Gender Identity:	<input type="checkbox"/> Female	<input type="checkbox"/> Male
<input type="checkbox"/> Non-Binary	<input type="checkbox"/> Not Specified	<input type="checkbox"/> Unknown
Sexual Orientation:	<input type="checkbox"/> Choose not to disclose	
<input type="checkbox"/> Bisexual	<input type="checkbox"/> Lesbian, gay, homosexual	<input type="checkbox"/> Pansexual
<input type="checkbox"/> Straight, heterosexual	<input type="checkbox"/> Other	<input type="checkbox"/> Unknown
Preferred Pronouns:		
<input type="checkbox"/> He/Him	<input type="checkbox"/> She/Her	<input type="checkbox"/> They/Them <input type="checkbox"/> Other: _____
Race:		
<input type="checkbox"/> African-American or black	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian
<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Pacific Islander	<input type="checkbox"/> White or Caucasian
<input type="checkbox"/> Unknown	<input type="checkbox"/> Other: _____	
Ethnic Origin:		
<input type="checkbox"/> Hispanic Origin: Cuban	<input type="checkbox"/> Hispanic Origin: Mexican	<input type="checkbox"/> Hispanic Origin: Other
<input type="checkbox"/> Hispanic Origin: Puerto Rican	<input type="checkbox"/> Not of Hispanic Origin	

Highest Year of Education Completed: _____					
Marital Status:		<input type="checkbox"/> Common Law	<input type="checkbox"/> Divorced		
<input type="checkbox"/> Living as Married		<input type="checkbox"/> Living Together	<input type="checkbox"/> Married		
<input type="checkbox"/> Never Married		<input type="checkbox"/> Remarried	<input type="checkbox"/> Separated		
<input type="checkbox"/> Widowed		<input type="checkbox"/> Unknown			
Hearing Status:		<input type="checkbox"/> Deaf	<input type="checkbox"/> Hard of Hearing		
<input type="checkbox"/> Normal		<input type="checkbox"/> Unknown			
Primary Language: _____			Preferred Language: _____		
Employment Status:		<input type="checkbox"/> Employed Full Time		<input type="checkbox"/> Employed Part Time	
<input type="checkbox"/> Disabled	<input type="checkbox"/> Homemaker	<input type="checkbox"/> Inmate	<input type="checkbox"/> Pre-School	<input type="checkbox"/> Retired	<input type="checkbox"/> Student
<input type="checkbox"/> Rcv. Support to Seek employment	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Seeking Employment	<input type="checkbox"/> Sheltered Workshop	<input type="checkbox"/> Supported Employment	<input type="checkbox"/> Unemployed
<input type="checkbox"/> Unemployed-Lay off		<input type="checkbox"/> Unknown			
Occupation: _____					
Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No Branch: _____ From/To Dates: _____					
Living Arrangements:		<input type="checkbox"/> Alone	<input type="checkbox"/> Homeless	<input type="checkbox"/> Homeless Shelter	<input type="checkbox"/> Jail Correctional Facility
<input type="checkbox"/> With Family	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Other	<input type="checkbox"/> Parent/Siblings	<input type="checkbox"/> Transitional	<input type="checkbox"/> Unrelated Person
<input type="checkbox"/> Spouse	<input type="checkbox"/> CSTAR Residential	<input type="checkbox"/> CSTAR Supported Housing	<input type="checkbox"/> Oxford House	<input type="checkbox"/> Residential Care Facility	<input type="checkbox"/> Under18 with both parents
<input type="checkbox"/> Under18 with Foster home	<input type="checkbox"/> Under18 with independent living	<input type="checkbox"/> Under18 with other relatives	<input type="checkbox"/> Under18 with other	<input type="checkbox"/> Under18 with Private care facility	<input type="checkbox"/> Under18 with Public care facility
<input type="checkbox"/> Under18 with Single parent	<input type="checkbox"/> Under18 with Parent/step-parent	<input type="checkbox"/> Unknown	<input type="checkbox"/> Refuse to Answer		

Annual Family Income: \$ _____ Number in Household: _____
Insurance: _____

EMERGENCY INFORMATION

Emergency Contact Name and Phone Number : _____
Emergency Contact Relationship to Client: _____
Referred By: _____

GUARDIAN INFORMATION

Name of Guardian (if you are not your own Guardian): _____
Are they here with you today? Yes No

Presenting Concerns:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Behavioral Issues | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Relationship issues | <input type="checkbox"/> Employment Issues | <input type="checkbox"/> Family Issues |
| <input type="checkbox"/> Financial Issues | <input type="checkbox"/> Gambling addiction | <input type="checkbox"/> Housing Issues | <input type="checkbox"/> Parenting Issues |
| <input type="checkbox"/> Internet misuse | <input type="checkbox"/> Legal Issues | <input type="checkbox"/> Marriage | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Decline in Grades |

- Grief/Loss Physical/Sexual Abuse Other _____
 Domestic Violence

Are you satisfied with your eating patterns? Yes No

Do you ever eat in secret? Yes No

MINI HEALTH SCREEN		
Do you have a Primary Care Physician/Pediatrician?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Physician Name: _____		
Have you had a physical exam in the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a Dentist	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you seen a dentist in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you or close family members (parents/grandparents) been diagnosed with any of the following conditions?		
	Self	Parent/Grandparent
Diabetes/Pre-Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hyperlipidemia (high cholesterol)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypertension (high blood pressure)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiovascular (heart) Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use tobacco or nicotine products (Vape, Juul, cigarettes, cigars, chewing tobacco, etc)?		
<input type="checkbox"/> Daily Use <input type="checkbox"/> Never Used <input type="checkbox"/> Occasional Use <input type="checkbox"/> Previous Use, no use in past 90 days <input type="checkbox"/> Unknown		
Have you received mental health or substance use treatment in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please explain: _____		
Are you currently receiving behavioral health services from another agency? _____		
If so, which agency, and for what purpose? _____		
Have you been hospitalized or gone to the emergency department in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Psychiatric reasons _____		
Medical reasons _____		
Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
If yes, are you receiving prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, name of provider or clinic _____		
How many times in the past year have you had		
Men- 5 or more drinks per day		
Women or all adults older than 65 years- 4 or more drinks per day		
<input type="checkbox"/> 0-1 times		
<input type="checkbox"/> 2-3 times		
<input type="checkbox"/> 4-5 times		
<input type="checkbox"/> 6+ times		

Please list all Prescription medications you are taking _____

Please mark any prescribed medications below that you are taking:

- Pain Medications Anxiety Medications Muscle Relaxants

Please list all Over the Counter medications you are taking _____