Compass Health Network

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 seeking Methadone treatment? If you answered YES are you in Clinton, Warsaw, Warrensburg, Higginsville, or Sedalia, please STOP completing this form and inform the front desk.

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: _____ **(required for Medicaid or other state funding programs)**

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

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

☐ Anger	☐ Anxiety	☐ Behavioral Issues	☐ Bipolar Disorder
☐ Depression	☐ Relationship issues	☐ Employment Issues	☐ Family Issues
☐ Financial Issues	☐ Gambling addiction	☐ Housing Issues	☐ Parenting Issues
☐ Internet misuse	☐ Legal Issues	☐ Marriage	☐ PTSD
☐ Stress	☐ Schizophrenia	☐ Substance Abuse	☐ 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? ☐ Yes ☐ No
Physician Name: _____
Have you had a physical exam in the last year? ☐ Yes ☐ No
Do you have a Dentist ☐ Yes ☐ No
Have you seen a dentist in the past year? ☐ Yes ☐ No

Have you or close family members (parents/grandparents) been diagnosed with any of the following conditions?

	Self	**Parent/Grandparent**
Diabetes/Pre-Diabetes	☐ Yes ☐ No	☐ Yes ☐ No
Hyperlipidemia (high cholesterol)	☐ Yes ☐ No	☐ Yes ☐ No
Obesity	☐ Yes ☐ No	☐ Yes ☐ No
Hypertension (high blood pressure)	☐ Yes ☐ No	☐ Yes ☐ No
Cardiovascular (heart) Disease	☐ Yes ☐ No	☐ Yes ☐ No

Do you use tobacco or nicotine products (Vape, Juul, cigarettes, cigars, chewing tobacco, etc)?
☐ Daily Use ☐ Never Used ☐ Occasional Use ☐ Previous Use, no use in past 90 days ☐ Unknown

Have you received mental health or substance use treatment in the past? ☐ Yes ☐ 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? ☐ Yes ☐ No
Psychiatric reasons _____
Medical reasons _____

Are you currently pregnant? ☐ Yes ☐ No ☐ Unknown
If yes, are you receiving prenatal care? ☐ Yes ☐ 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

- ☐ 0-1 times
- ☐ 2-3 times
- ☐ 4-5 times
- ☐ 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 _____

_____