

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 : _____

Are you currently feeling like harming yourself or anyone else? Yes No

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):	<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"/> Adult Foster Care
	<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"/> 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 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 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? 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	<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)?

- 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 _____