WELCOME
We are here to help

To better assist you, we ask that you 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 : _____

Alias: _____

1. Are you currently feeling like harming yourself or anyone else? ☐ Yes ☐ No
2. Are you here to complete SATOP services? ☐ Yes ☐ No

- If **YES to question #2 above,** please inform the front desk and discontinue completing this form.
- If **NO to question #2 above**, please continue answering the questions below.

Are you seeking opioid treatment? ☐ Yes ☐ No If you answered YES are you in Clinton, Warsaw, Warrensburg, Higginsville, or Sedalia, please STOP completing this form and inform the front desk.

Client Address: _____ City, State, Zip : _____

County: _____ Country of Residence, if other than US: _____

Client Home Number: _____ Can we leave a voicemail at this number? ☐Yes ☐No

Client Cell Phone: _____Can we leave a voicemail at this number? ☐Yes ☐No

Client Email Address: _____

Client Social Security Number: _____*(required for Medicaid or other state funding programs)*

How were you referred to Compass Health Network? _____

Birth Sex (Assigned at Birth): ☐Female ☐ Male

Gender Identity: (not required for patients under age 18)
☐ Female
☐ Male
☐ Non-Binary/Genderqueer, neither exclusively male nor female
☐ Choose not to disclose

Sexual Orientation: (not required for patients under age 18)
☐ Straight or heterosexual
☐ Bisexual
☐ Lesbian, gay or homosexual
☐ Something else, please describe._____
☐ Don't Know (patient does not know their sexual orientation)
☐ Choose not to disclose

Preferred Pronouns:

☐ She, Her, Hers
☐ He, Him, His
☐ They, Them, Theirs
☐ Other, Please describe _____

Race (select all that apply):

☐ African-American or Black
☐ American Indian or Alaskan Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Guamanian or Chamorro
☐ Japanese
☐ Korean
☐ Native Hawaiian
☐ Other Asian
☐ Other Pacific Islander
☐ Samoan
☐ Vietnamese
☐ White or Caucasian
☐ Choose not to disclose

Ethnicity:

☐ Hispanic Origin: Cuban
☐ Hispanic Origin: Mexican, Mexican American, Chicano/a
☐ Hispanic Origin: Puerto Rican
☐ Hispanic Origin: Other _____
☐ Not of Hispanic Origin

Highest Year of Education Completed: _____

Marital Status:

☐ Common Law
☐ Divorced
☐ Living as Married
☐ Living Together
☐ Married
☐ Never Married
☐ Remarried
☐ Separated
☐ Widowed

Hearing Status:

☐ Deaf ☐ Hard of Hearing ☐ Normal ☐ Unknown

Primary Language:_____ Preferred Language:_____

Employment Status:

☐ Employed Full Time (35+ hrs/week)
☐ Employed Part Time (<35 hrs/week)
☐ Disabled
☐ Homemaker
☐ Inmate
☐ Other
☐ Preschool
☐ Retired
☐ Student
☐ Receiving Support to Seek employment
☐ Seasonal Employment
☐ Seeking Employment
☐ Sheltered Workshop
☐ Supported Employment
☐ Unemployed
☐ Unemployed-Lay off

Occupation:_____

Military Services

Have you or an immediate family member ever served in the U.S. Armed Forces? ☐ Yes ☐No
Branch:_____ From/To Dates:_____

Have you ever served in the U.S. Armed Forces?	☐ Yes ☐ No
Are you currently serving in the U.S. Armed Forces?	☐ Yes ☐No
Are you currently serving in the National Guard?	☐ Yes ☐ No
Is the family member currently serving in the National Guard?	☐ Yes ☐No
Is the family member currently serving federal active duty?	☐ Yes ☐No

Living Arrangements:

☐ 18+ and Alone	☐ 18+ with Transitional	☐ Under 18 and homeless
☐ 18+ and Homeless	☐ 18+ with Unrelated Person	☐ Under 18 with independent living
☐ 18+ in Homeless Shelter	☐ 18+ with Spouse only	☐ Under 18 with other relatives
☐ 18+ in Jail/Correctional Facility	☐ CSTAR Residential	☐ Under 18 with other
☐ 18+ with Adult Foster Care	☐ CSTAR Supported Housing	☐ Under 18 with Private care facility
☐ 18+ with Family	☐ Oxford House	☐ Under 18 with Public care facility
☐ 18+ in Nursing Home	☐ Residential Care Facility	☐ Under 18 with Single parent
☐ 18+ with Other	☐ Under 18 with both parents	☐ Under 18 with Parent/step-parent
☐ 18+ with Parent/Siblings	☐ Under 18 with foster home	☐ Refuse to Answer

Homeless Status:

☐ Non Homeless
☐ Homeless Shelter
☐ Doubling Up (living with others, "couch surfing")
☐ Transitional Housing (small unit where people transition from a shelter)
☐ Street (living on street, vehicle, outdoors, or encampment)
☐ Other (reside in hotel/motel)

Migrant Worker Status:

Do you have family members that are agricultural workers? ☐ Yes ☐ No
Are you an aged and disabled former migratory agricultural worker? ☐ Yes ☐ No

Do you have a loved one who is a service member or veteran? ☐ Yes ☐ No

Guardian Name (if you are not your own Guardian): _____

Guardian Relationship to Patient:_____

Guardian Phone Number:_____

Guardian Address:_____

Emergency Contact Name: _____

Phone Number: _____

Emergency Contact Relationship to Client:_____

Annual Family Income: $_____ Number in Household: _____

Insurance: (*Provide insurance card(s) to front desk staff.)*

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	☐ Domestic Violence	☐ Other _____

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: _____

Physician Address: _____

Street City State Zip

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 _____

_____