Compass Health Network

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.

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 Name: _____ Alias/Preferred Name: _____

Sex (Assigned at Birth) ☐ Female ☐ Male ☐ Unknown Client Date of Birth : _____

How were you referred to Compass Health Network? _____

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

Client Address: _____ City, State, Zip : _____

Mailing Address (if different): _____ City, State, Zip : _____

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

Client Home Number: _____ Client Cell Phone: _____

Client Work Phone: _____ Client Email Address: _____

Is it okay to contact you? ☐Yes ☐ No

What is your communication preference? ☐ Email ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Text

Can we leave a voicemail message for you? (Check all numbers as appropriate)

☐ Home Phone ☐ Cell Phone ☐ Work Phone

Primary Language:_____ **Preferred Language:**_____

Do you require an interpreter? ☐Yes ☐ No

Client 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
☐ Decline

Ethnic Origin:

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

Have you experienced any type of homelessness in the past year?
☐ No
☐ Homeless Shelter
☐ Doubling Up (living with others, "couch surfing")
☐ Transitional Housing (small unit where people transition from a shelter)
☐ Living on the street (vehicle, outdoors, or encampment)
☐ Other (reside in hotel/motel)
☐ Unknown

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:_____

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

Highest Year of Education Completed: _____

Hearing Status:
☐ Deaf ☐ Hard of Hearing ☐ Normal ☐ Unknown

Gender Identity: (not required for patients under age 18)
☐ Choose not to disclose
☐ Female
☐ Male
☐ Non-Binary
☐ Other
☐ Transgender (FTM)
☐ Transgender (MTF)
☐ Unknown

Sexual Orientation: (not required for patients under age 18)

☐ Asexual
☐ Bisexual
☐ Chose not to Disclose
☐ Lesbian, gay or homosexual
☐ Other
☐ Pansexual
☐ Queer
☐ Questioning
☐ Straight or heterosexual
☐ Unknown

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

Tobacco Use
☐ Daily use of tobacco products
☐ Never used tobacco products
☐ Occasional use of tobacco products
☐ Previous use of tobacco products, with no use in the past 90 days
☐ Unknown

Are you planning to quit nicotine/tobacco?
☐ Yes, actively quitting
☐ Yes, plan to quit today
☐ Yes, plan to quit within 30 days
☐ Yes, plan to quit within 6 months
☐ Not sure
☐ No, not planning to quit at this time
☐ NA – previously quit

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

Migrant Worker Status:
Are you or a family member a current or former migratory or seasonal agricultural worker? ☐ Yes ☐ No

Military Services

What is your Military Service? ☐ Active Duty/Reserves/Guard ☐ Veteran ☐ N/A

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

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

Is the patient their own guardian? ☐ Yes ☐No If not, complete the table below. If yes, skip to Emergency Contact section.

Parent/Guardian (s)	Parent/Guardian 1	Parent/Guardian 2
Name:		
Relationship:		
Address:		
Phone		

Emergency Contact Name: _____

Emergency Contact Relationship to Client:_____

Address: _____

Phone Number: _____

Annual Family Income: $_____ Number in Household: _____

PLEASE PRESENT YOUR INSURANCE CARD TO FRONT DESK STAFF

Insurance: _____

Subscriber Information – *If someone other than the patient*

Subscriber Name: _____

Date of Birth: _____SSN: _____ Sex: ☐Male ☐Female

Relationship to Patient: _____

Address (if different than patient's): _____

Primary Phone: _____Alternate Phone: _____

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

Would you like Compass to collaborate (exchange records) with your primary care provider? ☐ 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 _____

_____

_____