Behavioral Health Registration

Please fill out the following information for the person who will be receiving Mental Health or Addiction Services. If you require assistance completing any of the forms please let an office staff know. Thank you!

WHAT SERVICES ARE YOU SEEKING?

☐Mental Health Counseling ☐Alcohol & Drug Treatment ☐Problem Gambling Counseling ☐Other ______________

CLIENT INFORMATION:

Last Name First Name MI	Social Security No.	Date of Birth	☐Male ☐Female ☐Other
Street Address City State Zip Code			Home Phone Leave messages? YES NO
Mailing Address (if different from above) City State Zip Code			Cell Phone Leave messages? YES NO
ODL/Oregon DMV# (required if legal status is DUII related)	How would you like to receive appointment reminders? TEXT PHONE EMAIL		Email

For Minor Children:
Parent Name: *(please print)* ______________________________
Parent Name: *(please print)* ______________________________

CLIENT INSURANCE INFORMATION:

Oregon Health Plan (OHP) ID #	Name of Mental Health Plan (if applicable)		Name of Medical Health Plan (if applicable)	
Medicare ID #	Coverage: Part A ☐ Part B ☐ Part D ☐			
Secondary Insurance Company	Group No.	ID#	Insurance Phone Number:	
Responsible Party (if different than insured)	Relationship	Date of Birth	Social Security No.	Phone Number
Is secondary insurance through: ☐Employer ☐Self-purchased ☐Absent Parent ☐Other				

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS *(please initial)*
_______I agree to be financially responsible and pay for the services provided to me by Polk County Behavioral Health if the services are not covered or fully paid by insurance. I understand that the law allows Polk County Behavioral Health to collect from me the amount owing. If I have health insurance, I hereby authorize Polk County Behavioral Health to furnish all applicable information required by the insurance company(ies) for payment of claims. I hereby assign Polk County Behavioral Health all monies to which I am entitled from insurance, for expense related to the services received from Polk County Behavioral Health. OYA Financial Exception

ACKNOWLEDGEMENT OF PRIVACY PRACTICES *(please initial)*
_______I have been given written information concerning Polk County Behavioral Health's Privacy Practices. I have had a chance to ask questions about how my information will be used.

ACKNOWLEDGEMENT OF CLIENT RIGHTS AND RESPONSIBILITIES *(please initial)*
_______I have been given written information concerning my Rights and Responsibilities while enrolled with Polk County Behavioral Health. I have had a chance to discuss any questions or concerns about this document with a Polk County Behavioral Health staff member.

CLIENT CONSENT
My initials beside the statements above indicate my understanding and agreement. I hereby authorize Polk County Behavioral Health to provide services for myself, or the named child/person for whom I am legal guardian for. I consent to evaluation and treatment which will be thoroughly discussed with me during the assessment. I understand that I have the right to ask questions of my provider about my treatment services at any time.

______________________________ ______________________________ ______________
Client or Legal Guardian Signature Relationship Date

Printed Name ______________________________

FORM # BH R001 (4/20)

MEDICAL INFORMATION

INDICATE SERVICES YOU HAVE RECEIVED IN THE PAST *Please indicate if we may request these records?*

Service	Provided By	ROI for Records Request:	
☐ Mental Health Counseling	Provided By: ______	YES	NO
☐ Med. Management	Provided By: ______	YES	NO
☐ A&D Treatment	Provided By: ______	YES	NO
☐ Gambling Treatment	Provided By: ______	YES	NO

PRIMARY CARE PROVIDER (PCP) Do you have a Primary Care Provider? ☐YES ☐NO

Dr. Name: ______ Clinic Name/Location: ______

MEDICATIONS/ALLERGIES

Do you have any Allergies to Medication? If yes, ☐YES ☐NO
please list: ______

If you are currently being prescribed any of the following medications, please mark all that apply:

Medication	Prescriber
☐ Abilify/aripiprazole	______
☐ Clozaril, Frazalco/clozapine	______
☐ Geodon/ziprasidone	______
☐ Haldol/haloperidol	______
☐ Invega/pallperidone	______
☐ Risperdal/risperidone	______
☐ Seroquel/quetiapine	______
☐ Zyprexa/olanzapine	______

Medication	Prescriber
BENZODIAZAPINES:	
☐ Ativan/loraepam	______
☐ Klonopin/clonazepam	______
☐ Valium/diazepam	______
☐ Xanax/alpraolam	______
☐ Librium/chlordiazepoxide	______

Medication	Prescriber
STIMULANT DRUGS:	
☐ Adderall	______
☐ Adderall XR	______
☐ Concerta	______
☐ Dexedrine	______
☐ Dexedrine spansule	______
☐ Daytrana	______
☐ Metadate CD	______
☐ Metadate ER	______
☐ Methylin ER	______
☐ Ritalin	______
☐ Ritalin LA	______
☐ Ritalin SR	______
☐ Vyvanse	______
☐ Quillivant XR	______

Medication	Prescriber
OTHER:	
☐ Vicodin	______
☐ Oxycontin	______
☐ Fentanyl/Duragesic/Fentora	______
☐ Lorcet/Lortab/Norco	______
☐ Hydromorphone/Dilaudid	______
☐ Meperidine/Demerol	______
☐ Methadone/Dolophine	______
☐ Morphine/MS Contin	______
☐ Oxycodone	______
☐ Oxyfast/Roxicodone	______
☐ Targiniq ER	______
☐ Percocet	______
☐ Tramadal	______
☐ Suboxone	______

Other prescribed drugs not on this list:

______

______

Are you Pregnant? ☐YES ☐NO

Do you use Tobacco? ☐YES ☐NO

Do you now or have you ever used IV Drugs? YES☐ NO ☐

Have you used non-prescribed drugs or alcohol in the past 90 days? ☐YES ☐NO

DEMOGRAPHIC INFORMATION *Because we are a Medicaid provider, we are required to ask the following questions.*

1. Client last name at birth? ______________________

2. Do you need an interpreter? ☐ YES ☐ NO ☐ Hearing impaired? Primary Language: ______________

3. Is the client a veteran? ☐ YES ☐ NO ☐ Current or Former Guard/Reserve Military ☐ Current or Former Active Duty Military

4. What is client's legal status? *(mark all that apply)*
☐ None ☐ DUII Conviction ☐ DUII Diversion ☐ Parole ☐ Probation ☐ Child Welfare Guardianship ☐ Court Guardianship (non-DHS)

5. What is the highest grade completed by client? ______ If currently a student, what school does client attend? ______________

6. What is client's county of residence? ☐ Polk ☐ Marion ☐ Other ______________

7. What is client's marital status? (*If living as married, please check married*)
☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

8. What is client's employment? (mark all that apply)
☐ Full Time ☐ Part Time ☐ Unemployed ☐ Disabled ☐ Not in Labor Force
☐ Student ☐ Homemaker ☐ Retired ☐ Other: ______________

8a. Are you interested in receiving information about how to find employment? ☐ YES ☐ NO

9. What is the primary source of income/support for client or parent of client?
☐ Wages/Salary ☐ Public Assistance ☐ Disability/SSDI ☐ Retirement/Pension/SSI
☐ Other ☐ None

10. Estimated Gross Monthly Household Income: ☐ No Income ☐ Refuse to Answer

11. What is the total number of people dependent upon household income?

12. How many children ages 0-17 that are dependent upon the household income?

13. What is the client's living arrangement?
☐ Live Alone ☐ Live w/Significant Other ☐ Live w/ Parent ☐ Foster Home
☐ Jail ☐ Oxford Home ☐ Residential Facility ☐ Room & Board
☐ Supported Living ☐ Homeless ☐ Other

14. Please list the number of:
DUII Arrests in the past month: _____ DUII Arrests in your lifetime: _____
Arrests in the past month: _____ Arrests in your lifetime: _____

15. Which of the following best describes client's:

Race? *Mark all that apply*
☐ White ☐ Alaska Native ☐ American Indian ☐ Black or African American
☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Other Single Race

Ethnicity?
☐ Not of Hispanic Origin ☐ Cuban ☐ Mexican ☐ Puerto Rican
☐ Other Specific Hispanic ______________

Tribal Affiliation ? *Mark all that apply*
☐ Not Applicable ☐ Burns Paiute ☐ Conf. Tribe Coos, Lower Ump & Siuslaw
☐ Conf. Tribe of Grand Ronde ☐ Conf. Tribe of Siletz ☐ Conf. Tribe of Umatilla
☐ Conf. Tribe of Warm Springs ☐ Coquille Indian Tribe ☐ Cow Creek/Ump Indians
☐ Klamath Tribes ☐ Other ______________

16. Who Referred You To Us? *(mark all that apply)*
☐ Self ☐ Police or Sheriff ☐ State Prison
☐ Family/Friend ☐ Parole ☐ Federal Prison
☐ Doctor, Nurse, or Physician ☐ Probation ☐ State Psychiatric Facility
☐ Crisis Helpline ☐ Employer ☐ PSRB Board
☐ Media, Internet Advocacy ☐ Employment Services ☐ Municipal Court Justice
☐ Group ☐ Vocational Rehabilitation ☐ Court
☐ School ☐ Attorney ☐ Circuit Court
☐ DD Services ☐ Child Welfare ☐ Federal Court
☐ Aging & Disability ☐ Health Plan/CCO ☐ None
☐ ADES ☐ Jail ☐ Other ______________

FOR OFFICE USE ONLY

RECEIVED BY: ______________________ CLIENT ID# ______________

Initial Screen for Mental Health Services

Please mark all symptoms you have experienced in the last 2 weeks or are currently concerned about.

- ☐ Depressed mood
- ☐ Weight loss/gain
- ☐ Difficulty sleeping
- ☐ Feeling worthless/hopeless
- ☐ Irritability
- ☐ Panic attacks
- ☐ Excessive worry
- ☐ Difficulty concentrating
- ☐ Angry outbursts
- ☐ Nightmares
- ☐ Easily startled
- ☐ Seeing or hearing things others do not
- ☐ Obsessive thoughts
- ☐ Having to repeat a behavior over and over
- ☐ Difficulty listening
- ☐ Difficulty following directions
- ☐ Frequently interrupting others
- ☐ Frequently forgetful
- ☐ Frequently losing important items
- ☐ Difficulty making decisions

Please mark yes to any of the following questions which are applicable to you:

- ☐ Have you had thoughts or attempted to **hurt yourself** *in the past*?
- ☐ Have you had thoughts or attempted to **hurt yourself** *recently*?
- ☐ Have you had thoughts or attempted to **hurt someone else** *in the past*?
- ☐ Have you had thoughts or attempted to **hurt someone else** *recently*?
- ☐ Have you recently been physically hurt or threatened by someone else?

Have you ever been in a traumatic event?

- ☐ Yes
- ☐ No

If yes, mark all that apply:

- ☐ Bad car accident
- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Witness to Extreme Violence
- ☐ Natural Disaster (Fire, Flood, etc...)
- ☐ Life threatening injury or illness
- ☐ Serious injury you caused someone else
- ☐ Neglect
- ☐ Serious accident at work or home
- ☐ Threats of violence against you

Please indicate any of the following statements you would say yes to:

- ☐ Have you ever felt you should cut down on your gambling?
- ☐ Have you ever had relationship, financial and/or legal problems due to gambling?
- ☐ In the last year, have you had more than 4 drinks (woman) or 5 drinks (man) in a single day?
- ☐ Have you ever had relationship, financial and/or legal problems due to substance use?

Please give this to your counselor during your Intake Assessment.

South Oaks Gambling Screen

Client Name: ___________________________ Date: ______________________

Please indicate below which of the following types of gambling you have played in your lifetime:

		None	Less than once weekly	More than once weekly
1.	Play cards for money	☐	☐	☐
2.	Bet on horses, dogs or other animals at OTB, the track or with a bookie	☐	☐	☐
3.	Bet on sports (parlay cards, with a bookie or Jai Alai)	☐	☐	☐
4.	Played dice (including craps, over and under or other dice games) for money	☐	☐	☐
5.	Went to a casino (legal or otherwise)	☐	☐	☐
6.	Play the numbers or bet on lotteries	☐	☐	☐
7.	Played bingo	☐	☐	☐
8.	Played the stock or commodities market	☐	☐	☐
9.	Played slot machines, poker machines or other gambling machines	☐	☐	☐
10.	Bowled, shot pool, play golf or some other game of skill for money	☐	☐	☐
11.	Some form of gambling not listed. Please specify:	☐	☐	☐

What is the largest amount of money you have ever gambled with on any one day?

☐ Have never gambled
☐ Less than $1
☐ More than $1 up to $10
☐ More than $100 up to $1000
☐ More than $1000 up to $10,000
☐ More than $10,000

Do (did) your parents have a gambling problem?

☐ Both of my parents gamble(d) too much
☐ My mother gambles (or gambled) too much
☐ My father gambles (or gambled) too much
☐ Neither parent gambles (or gambled) too much

When you gamble, how often do you go back another day to try to win back what you lost?

☐ Never
☐ Some of the time (less than half the time)
☐ Most of the time I lost
☐ Every time I lost

Have you ever claimed to be winning money gambling, but actually been losing?

☐ Never (or never gamble) ☐ Yes, less than half the time I lost ☐ Yes, most of the time I lost

Do you feel you have ever had a problem with gambling?

☐ No ☐ Yes, in the past, but not now ☐ Yes

	Yes	No
Have you ever gambled more than you intended?	☐	☐
Have people criticized your gambling?	☐	☐
Have you ever felt guilty about the way you gamble or what happened when you gamble?	☐	☐
Have you ever felt like you would like to stop gambling but did not think you could?	☐	☐
Have you ever hidden betting slips, lottery tickets, gambling money, or other signs of gambling from your spouse, children or other important people in your life?	☐	☐
Have you ever argued with people you live with over how you handle money?	☐	☐
• If yes, have money arguments ever centered on your gambling?	☐	☐
Have you ever borrowed money from someone and not paid them back due to gambling?	☐	☐
Have you ever lost time from work or school due to gambling?	☐	☐
If you borrowed money to pay gambling debts or gamble, who and where did borrow from?		
• From household money	☐	☐
• From your spouse	☐	☐
• From other relatives or in-laws	☐	☐
• From banks, loan companies or credit unions	☐	☐
• From credit cards	☐	☐
• From loan sharks	☐	☐
• You cashed in stocks, bonds or other securities	☐	☐
• You sold personal or family property	☐	☐
• You borrowed on your checking account (passed a bad check)	☐	☐
• You have (had) a credit line with a bookie	☐	☐
• You have (had) a credit line with a casino	☐	☐

Please give this to your counselor during your Intake Assessment.