

FOUNDATIONS COUNSELING



Intake Demographics

Name: _____ Preferred Name: _____

SSN: _____ - _____ - _____ Date of Birth: _____ Phone: (____) _____

Address: _____ APT/SUITE#: _____

City & State: _____ Zip Code: _____

Legal Gender: Male Female Identified Gender: _____ Preferred Pronoun: _____

Race: American Indian/Alaskan Native Asian Black/African American Hispanic/Latino
 Native Hawaiian/Other Pacific Islander White Other _____

Ethnicity: Hispanic Orientation Not Hispanic or Latino

Living Arrangements: Private Residence Permanent Supportive Housing
 Residential Care/Group Home/ACF Community Residence Temporary Housing (including HWH)
 Foster Care Homeless DD Licensed/Operated Facility Correctional Facility Other _____

Number of children in household under 18: _____

Marital Status: Married Divorced Single Separated Widowed Other _____

Highest Education Level Completed: Grade School High School High School Diploma/GED
 Technical School Some College 2 YR College/Assoc. Degree 4 YR College Graduate Degree
 Other _____

Current Education Enrollment: K-12th GED classes College Vocation/Job Training Not attended school
in the last 3 months Other _____

Employment Status: Full Time Part Time Unemployed, but actively looking for work Homemaker
 Disabled Retired Student Volunteer Work Residential Facility Inmate in jail/prison/corrections
 Other _____

Primary Source of Income: Wages/Salary Disability (SSI/SSD, WC) Family/Relative Public Assistance
 Retirement/Pension None Other _____

Military Status: Active Discharged Disabled Veteran Branch _____ None

Tobacco Use: Current Former Never

If current or former please select type: Cigarette Smokeless Vape Other _____

FOUNDATIONS COUNSELING



Referral Source

- Self-referred
- School
- Employer/EAP
- Butler County Children Services
- Butler County Adult Probation/Common Pleas Court Area I Area II Area III
- Fairfield Municipal Court
- Hamilton Municipal Court
- Middletown Municipal Court
- Butler County Juvenile Probation
- Other Court/Criminal Justice
- Jail/Prison
- TASC
- State Psychiatric Hospital
- Mental Health Provider
- Primary Care Provider
- Other _____

Referral Source Name and Contact Information: _____

Any arrests in the past 30 days? No Yes If yes, how many? _____

Do you have a history of mental health? No Yes

Are you interested in seeking therapy for mental health? No Yes

Have you received treatment for substance use? No Yes

Are you interested in seek help for substance use? No Yes

Are you interested in seeing a psychiatric provider and medication management? No Yes

FOUNDATIONS COUNSELING



MINOR BILLING INFORMATION FORM

CLIENT NAME: _____ LEGAL GENDER: F M IDENTIFIED GENDER _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

SOCIAL SECURITY #: _____ BIRTHDATE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: () _____

EMERGENCY CONTACT: _____ PHONE: () _____

CUSTODIAL PARENT NAME: _____ PRIMARY PHONE: () _____

EMAIL ADDRESS: _____ May we identify Foundations? Y N

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

SPOUSE'S NAME: _____ PRIMARY PHONE: () _____

NON-CUSTODIAL PARENT: _____ PRIMARY PHONE: () _____

May we identify Foundations? Y N

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

WHO REFERRED YOU? _____

INSURED PARTY: _____ BIRTHDATE: _____

EMPLOYER: _____ SOC. SEC. #: _____

INSURANCE CO: _____

CLAIMS ADDRESS: _____

INS. CO. PHONE: () _____ POLICY: _____

I understand and agree that **regardless of my insurance status I am ultimately responsible for the balance on my account for any professional services rendered**, and that payment is due at the time those services are rendered. I further understand that the initial one to three sessions are for the purpose of evaluation (i.e., to determine whether or not a treatment relationship will be established) and as such do not guarantee acceptance as a Foundations client. **I have read all the information on both sides of this sheet and agree to the conditions set forth. I certify this information is true and correct to the best of my knowledge and will notify you of any changes in my status or the above information.**

I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that Foundations, the counselors, and other Foundations staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill, and for issues that concern Foundations operations and responsibilities.

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

Health History Questionnaire

This form should be completed as fully as possible by client but reviewed by medical staff

Client Name:	Client #:	Age:	Date:
---------------------	------------------	-------------	--------------

Review of Health Problems: Has the client had any of the following health problems?

	Now	Past	Never	Document Treatment Received and Date(s)
Anemia				
Arthritis				
Asthma				
Bleeding Disorder				
Blood Pressure (high or low)				
Bone/Joint Problems				
Cancer				
Cirrhosis/Liver Disease				
Diabetes				
Epilepsy/Seizure Disorder				
Eye Disease/Blindness				
Fibromyalgia/Muscle Pain				
Glaucoma				
Headaches				
Head Injury/Brain Tumor				
Hearing Problems/Deafness				
Heart Disease				
Hepatitis/Jaundice				
Kidney Disease				
Lung Disease				
Menstrual Pain				
Oral/Health/Dental Problems				
Stomach/Bowel Problems				
Stroke				
Thyroid				
Tuberculosis				
AIDS/HIV				
Sexually Transmitted Disease				
Learning Problems				
Speech Problems				
Anxiety				
Bipolar Depression				
Depression				
Eating Disorder				
Hyperactivity/ADD				
Schizophrenia				
Sexual Problems				
Sleep Disorder				
Suicide Attempts/Thoughts				
Other:				
Other:				

Please note family history of the above conditions and client's relationship to that family member:

Additional Health Information

Has client had medical hospitalizations and/or surgical procedures in the last 3 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, please list HOSPITAL, CITY, DATE, REASON for hospitalizations and/or surgical procedures:		

Allergies/Drug Sensitivities

<input type="checkbox"/> No Known Allergies
<input type="checkbox"/> Food (specify):
<input type="checkbox"/> Medication (specify):
<input type="checkbox"/> Other (specify):

Pregnancy History - FEMALES ONLY

<input type="checkbox"/> N/A (If N/A, you may skip this section)					
Currently Pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, expected delivery date:		
Are you receiving Prenatal Healthcare?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you take prenatal vitamins?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, who is your provider?					
Currently Breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When was your last menstrual cycle?		
Any Significant Pregnancy History?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
If yes, explain:					

DO NOT LEAVE THIS SECTION BLANK

Who is your PRIMARY CARE PROVIDER? (name and estimated date last seen)

Has client had any of the following symptoms in the past 60 days? (check all that apply)				
<input type="checkbox"/> Ankle Swelling	<input type="checkbox"/> Coughing	<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Penile Discharge	<input type="checkbox"/> Urination Difficulties
<input type="checkbox"/> Bed-Wetting	<input type="checkbox"/> Cramps	<input type="checkbox"/> Memory Problems	<input type="checkbox"/> Vaginal Discharge	<input type="checkbox"/> Pulse Irregularities
<input type="checkbox"/> Vision Changes	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Mole/Wart Changes	<input type="checkbox"/> Seizures
<input type="checkbox"/> Breathing Difficulties	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Shakiness	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Falling	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Sleep Problems	<input type="checkbox"/> Other:
<input type="checkbox"/> Confusion	<input type="checkbox"/> Gait Unsteadiness	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Sweats (night)	<input type="checkbox"/> Other:
<input type="checkbox"/> Consciousness Loss	<input type="checkbox"/> Hair Changes	<input type="checkbox"/> Numbness	<input type="checkbox"/> Tingling in Arms/Legs	<input type="checkbox"/> Other:
<input type="checkbox"/> Constipation	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Tremors	<input type="checkbox"/> Other:

Immunization - Vaccines (check all that apply)

<input type="checkbox"/> N/A	<input type="checkbox"/> COVID-19	<input type="checkbox"/> Dengue	<input type="checkbox"/> Chickenpox (Varicella)	<input type="checkbox"/> Pneumococcal
<input type="checkbox"/> Diphtheria*	<input type="checkbox"/> Flu (Influenza)	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Rubella
<input type="checkbox"/> Measles**	<input type="checkbox"/> Mumps**	<input type="checkbox"/> Rotovirus	<input type="checkbox"/> HPV (Human Papillomavirus)	<input type="checkbox"/> (German Measles)**
<input type="checkbox"/> Tetanus (Lock Jaw)*	<input type="checkbox"/> Pertussis	<input type="checkbox"/> Shingles	<input type="checkbox"/> Hib (Haemophilus influenzae type b)	
<input type="checkbox"/> Meningococcal	<input type="checkbox"/> (Whooping Cough)*	<input type="checkbox"/> (Herpes Roster)	<input type="checkbox"/> Polio (Poliomyelitis)	<input type="checkbox"/> Other:

Vaccines received within the past year (if applicable):

--

*Given in combination as DtaP

**Given in combination as MMR

Source: Centers for Disease Control and Prevention

Additional Health Information

Height/Weight

Height:			
If reporting for a child, has height changed in the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, by how much (+ or -)?			
Weight:			
Has client's weight changed in the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
By how much (+ or -)?			
Have you gained or lost more than 10 pounds in the last 3 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Nutritional Screening

Drinking	<input type="checkbox"/> No Change	<input type="checkbox"/> Less	<input type="checkbox"/> More	<input type="checkbox"/> Takes Liquids Only	
Eating	<input type="checkbox"/> No Change	<input type="checkbox"/> Less	<input type="checkbox"/> More	<input type="checkbox"/> Not Eating	
Appetite	<input type="checkbox"/> No Change	<input type="checkbox"/> Decreased	<input type="checkbox"/> Increased		
Are you satisfied with your eating patterns?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Do you ever eat in secret?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Do you make yourself sick because you feel uncomfortably full?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Do you worry you have lost control over how much you eat?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Does your weight affect how you feel?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Do you currently suffer with or have you suffered from an eating disorder in the past?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Have any members of your family suffered from an eating disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Additional Comments :					

Dental History

Approximate Date of Last Dental Exam (month/year):					
Name of Dentist:					
Are you having dental problems now?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Are you apprehensive about dental treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Are your teeth sensitive to hot, cold, sweets, pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Do you brush your teeth daily?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Do you wear dentures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Have you ever had periodontal (gum) treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Do your gums bleed, or feel tender or irritated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Do you have headaches, earaches, or neck pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Do you regularly use dental floss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Additional Comments:					

Pain Screening

Are you experiencing paing today?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, on a level of 1-10, how would you rate your pain?			
Does pain currently interfere with your activities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, how much does it interfere with these activities? <input type="checkbox"/> Mildly <input type="checkbox"/> Moderately <input type="checkbox"/> Extremely <input type="checkbox"/> Severely			
Please indicate the source of your pain:			

Substance Use History

Substance Use History and Current Use

Alcohol/Beer/Wine	<input type="checkbox"/> No Use	<input type="checkbox"/> Past Use	<input type="checkbox"/> Current Use	
Marijuana	<input type="checkbox"/> No Use	<input type="checkbox"/> Past Use	<input type="checkbox"/> Current Use	
Hashish	<input type="checkbox"/> No Use	<input type="checkbox"/> Past Use	<input type="checkbox"/> Current Use	
Stimulants	<input type="checkbox"/> No Use	<input type="checkbox"/> Past Use	<input type="checkbox"/> Current Use	
Sleep Medication	<input type="checkbox"/> No Use	<input type="checkbox"/> Past Use	<input type="checkbox"/> Current Use	
Tranquilizers	<input type="checkbox"/> No Use	<input type="checkbox"/> Past Use	<input type="checkbox"/> Current Use	
Hallucinogens	<input type="checkbox"/> No Use	<input type="checkbox"/> Past Use	<input type="checkbox"/> Current Use	
Inhalants	<input type="checkbox"/> No Use	<input type="checkbox"/> Past Use	<input type="checkbox"/> Current Use	
Cocaine/Crack	<input type="checkbox"/> No Use	<input type="checkbox"/> Past Use	<input type="checkbox"/> Current Use	
Opioids (i.e. Heroin)	<input type="checkbox"/> No Use	<input type="checkbox"/> Past Use	<input type="checkbox"/> Current Use	
Pain Medication	<input type="checkbox"/> No Use	<input type="checkbox"/> Past Use	<input type="checkbox"/> Current Use	
Other:				
Caffeine use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
What form(s) of caffeine do you use?				
How much do you consume each week (i.e. cups, bottles, etc.)?				
Tobacco use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
What form(s) of tobacco do you use?				
How much do you use each week (i.e. packs, etc.)?				

OFFICE USE ONLY

Comments, Recommendations, or Referrals by Medical Reviewer

No Referral Needed
 Primary Care Physician
 Healthcare Agency
 Specialty Care

Specify Action(s)

Were the Provider's recommendations shared with client?

Yes

No

If yes, document client's response:

If no, how will the recommendations be shared with the client?