People Quality Integrity Compassion Community

FOUNDATIONS COUNSELING

COMMUNITY FIRST SOLUTIONS

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 _______________________

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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

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COMMUNITY FIRST SOLUTIONS

BILLING INFORMATION FORM

CLIENT NAME:_______________________ LEGAL GENDER: F M IDENTIFIED GENDER: ____________

BIRTHDATE: __________ EMAIL ADDRESS: ______________________________

PRIMARY PHONE: (____) __________ SECONDARY PHONE: (___) __________ May we identify Foundations? Y N

HOME ADDRESS: ____________________ CITY: ____________ STATE: _____ ZIP CODE: ______

EMPLOYER: ______________________________ SOC. SEC. #:______________

SPOUSE'S NAME: ______________ PHONE: (___) ______SPOUSE'S EMPLOYER: ____________

NEAREST RELATIVE
NOT LIVING WITH YOU: ______________________________ PHONE: (___) __________

PRIMARY CARE PHYSICIAN: ______________________________ PHONE: (___) __________

EMERGENCY CONTACT: ______________________________ PHONE: (___) __________

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?	☐ Yes	☐ No	
If YES, please list HOSPITAL, CITY, DATE, REASON for hospitalizations and/or surgical procedures:			

Allergies/Drug Sensitivities

☐	No Known Allergies
☐	Food (specify):
☐	Medication (specify):
☐	Other (specify):

Pregnancy History - FEMALES ONLY

☐ N/A (If N/A, you may skip this section)							
Currently Pregnant?	☐ Yes	☐ No	If yes, expected delivery date:				
Are you receiving Prenatal Healthcare?		☐ Yes	☐ No	Do you take prenatal vitamins?	☐ Yes	☐ No	
If yes, who is your provider?							
Currently Breastfeeding?	☐ Yes	☐ No	When was your last menstrual cycle?				
Any Significant Pregnancy History?	☐ Yes	☐ 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)				
☐ Ankle Swelling	☐ Coughing	☐ Lightheadedness	☐ Penile Discharge	☐ Urination Difficulties
☐ Bed-Wetting	☐ Cramps	☐ Memory Problems	☐ Vaginal Discharge	☐ Pulse Irregularities
☐ Vision Changes	☐ Blood in Stool	☐ Diarrhea	☐ Mole/Wart Changes	☐ Seizures
☐ Breathing Difficulties	☐ Dizziness	☐ Muscle Weakness	☐ Shakiness	☐ Vomiting
☐ Chest Pain	☐ Falling	☐ Nervousness	☐ Sleep Problems	☐ Other:
☐ Confusion	☐ Gait Unsteadiness	☐ Nosebleeds	☐ Sweats (night)	☐ Other:
☐ Consciousness Loss	☐ Hair Changes	☐ Numbness	☐ Tingling in Arms/Legs	☐ Other:
☐ Constipation	☐ Hearing Loss	☐ Panic Attacks	☐ Tremors	☐ Other:

Immunization - Vaccines (check all that apply)

☐ **N/A**	☐ COVID-19	☐ Dengue	☐ Chickenpox (Varicella)	☐ Pneumococcal
☐ Diphtheria*	☐ Flu (Influenza)	☐ Hepatitis A	☐ Hepatitis B	☐ Rubella (German Measles)**
☐ Measles**	☐ Mumps**	☐ Rotovirus	☐ HPV (Human Papillomavirus)	
☐ Tetanus (Lock Jaw)*	☐ Pertussis (Whooping Cough)*	☐ Shingles (Herpes Roster)	☐ Hib (Haemophilus influenzae type b)	
☐ Meningoccocal			☐ Polio (Poliomyelitis)	☐ 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?	☐ Yes	☐ No	
If yes, by how much (+ or -)?			
Weight:			
Has client's weight changed in the past year?	☐ Yes	☐ No	
By how much (+ or -)?			
Have you gained or lost more than 10 pounds in the last 3 months?	☐ Yes	☐ No	

Nutritional Screening

Drinking	☐ No Change	☐ Less	☐ More	☐ Takes Liquids Only
Eating	☐ No Change	☐ Less	☐ More	☐ Not Eating
Appetite	☐ No Change	☐ Decreased	☐ Increased	

Are you satisfied with your eating patterns?	☐ Yes	☐ No	
Do you ever eat in secret?	☐ Yes	☐ No	
Do you make yourself sick because you feel uncomfortably full?	☐ Yes	☐ No	
Do you worry you have lost control over how much you eat?	☐ Yes	☐ No	
Does your weight affect how you feel?	☐ Yes	☐ No	
Do you currently suffer with or have you suffered from an eating disorder in the past?	☐ Yes	☐ No	
Have any members of your family suffered from an eating disorder?	☐ Yes	☐ No	
Additional Comments :			

Dental History

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

Pain Screening

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

Substance Use History

Substance Use History and Current Use

Alcohol/Beer/Wine	☐ No Use	☐ Past Use	☐ Current Use	
Marijuana	☐ No Use	☐ Past Use	☐ Current Use	
Hashish	☐ No Use	☐ Past Use	☐ Current Use	
Stimulants	☐ No Use	☐ Past Use	☐ Current Use	
Sleep Medication	☐ No Use	☐ Past Use	☐ Current Use	
Tranquilizers	☐ No Use	☐ Past Use	☐ Current Use	
Hallucinogens	☐ No Use	☐ Past Use	☐ Current Use	
Inhalants	☐ No Use	☐ Past Use	☐ Current Use	
Cocaine/Crack	☐ No Use	☐ Past Use	☐ Current Use	
Opioids (i.e. Heroin)	☐ No Use	☐ Past Use	☐ Current Use	
Pain Medication	☐ No Use	☐ Past Use	☐ Current Use	
Other:				
Caffeine use?	☐ Yes	☐ No		
What form(s) of caffeine do you use?				
How much do you consume each week (i.e. cups, bottles, etc.)?				
Tobacco use?	☐ Yes	☐ 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 repsonse:			
If no, how will the recommendations be shared with the client?			