

HANOVER COUNTY COMMUNITY SERVICES BOARD INFORMATION FORM

What Brings You Here Today?

First Name:	Middle Name:	Last Name:
Name You Prefer to be Called:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Email Address:
Address:	City and State:	Zip Code:
In what County do you live? <input type="checkbox"/> Hanover <input type="checkbox"/> Other: _____	DOB:	SSN:
Home Phone:	Work Phone:	Cell Phone:

<p><u>Marital Status (or that of parent/guardian, if minor):</u></p> <p><input type="checkbox"/> Single</p> <p><input type="checkbox"/> Married</p> <p><input type="checkbox"/> Living with Significant Other</p> <p><input type="checkbox"/> Divorced, Separated, or Widowed</p>	<p>Family Size (including self, spouse/significant other, and children under age 18 living in the household): _____</p> <p>Responsible Party (for billing purposes): _____</p>			
<p><u>Employment Status:</u></p> <p>Current Employer, if any: _____</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; padding: 5px;"> <input type="checkbox"/> Full Time <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Employment Program/Supported Employment <input type="checkbox"/> Unemployment Not Seeking Job </td> <td style="width: 50%; vertical-align: top; padding: 5px;"> <input type="checkbox"/> Part Time <input type="checkbox"/> Homemaker <input type="checkbox"/> Not in Labor Force – In Institution <input type="checkbox"/> Not in Labor Force – Sheltered Employment Setting <input type="checkbox"/> Not In Labor Force – Disabled <input type="checkbox"/> Unemployed Seeking Job </td> </tr> </table>		<input type="checkbox"/> Full Time <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Employment Program/Supported Employment <input type="checkbox"/> Unemployment Not Seeking Job	<input type="checkbox"/> Part Time <input type="checkbox"/> Homemaker <input type="checkbox"/> Not in Labor Force – In Institution <input type="checkbox"/> Not in Labor Force – Sheltered Employment Setting <input type="checkbox"/> Not In Labor Force – Disabled <input type="checkbox"/> Unemployed Seeking Job	
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<p><u>Educational Level:</u></p> <p>Current School, if any: _____</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top; padding: 5px;"> <input type="checkbox"/> None <input type="checkbox"/> Special Education:Self-Contained only <input type="checkbox"/> Pre-School, Head-Start <input type="checkbox"/> Kindergarten <input type="checkbox"/> Grade 1 <input type="checkbox"/> Grade 2 <input type="checkbox"/> Grade 3 </td> <td style="width: 33%; vertical-align: top; padding: 5px;"> <input type="checkbox"/> Grade 4 <input type="checkbox"/> Grade 5 <input type="checkbox"/> Grade 6 <input type="checkbox"/> Grade 7 <input type="checkbox"/> Grade 8 <input type="checkbox"/> Grade 9 <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 11 </td> <td style="width: 33%; vertical-align: top; padding: 5px;"> <input type="checkbox"/> Grade 12/GED <input type="checkbox"/> Vocational Education <input type="checkbox"/> College: Freshman <input type="checkbox"/> College: Sophomore <input type="checkbox"/> College: Junior <input type="checkbox"/> College: Senior <input type="checkbox"/> Graduate/Professional Prog. </td> </tr> </table>		<input type="checkbox"/> None <input type="checkbox"/> Special Education:Self-Contained only <input type="checkbox"/> Pre-School, Head-Start <input type="checkbox"/> Kindergarten <input type="checkbox"/> Grade 1 <input type="checkbox"/> Grade 2 <input type="checkbox"/> Grade 3	<input type="checkbox"/> Grade 4 <input type="checkbox"/> Grade 5 <input type="checkbox"/> Grade 6 <input type="checkbox"/> Grade 7 <input type="checkbox"/> Grade 8 <input type="checkbox"/> Grade 9 <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 11	<input type="checkbox"/> Grade 12/GED <input type="checkbox"/> Vocational Education <input type="checkbox"/> College: Freshman <input type="checkbox"/> College: Sophomore <input type="checkbox"/> College: Junior <input type="checkbox"/> College: Senior <input type="checkbox"/> Graduate/Professional Prog.
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School Attendance Status:

If person seeking services meets either criteria below, please check category and answer the attendance question; skip if criteria not met

3-17 years of age **OR** 18-21 in Special Education

Have you attended school at least one day during the past 3 months (if on summer break, respond YES)? Yes No

Referral Source:

- | | | |
|--|--|---|
| <input type="checkbox"/> Self | <input type="checkbox"/> Family or Friend | <input type="checkbox"/> Private Physician |
| <input type="checkbox"/> Private Mental Health Provider | <input type="checkbox"/> Police or Sheriff | <input type="checkbox"/> Court Referral |
| <input type="checkbox"/> Local Correctional Facility | <input type="checkbox"/> State Correctional Facility | <input type="checkbox"/> Private ID/DD Provider |
| <input type="checkbox"/> Other VA Community Services Board | <input type="checkbox"/> Probation Office | <input type="checkbox"/> Private Hospital |
| <input type="checkbox"/> School System | <input type="checkbox"/> Parole Office | <input type="checkbox"/> State Hospital |
| <input type="checkbox"/> ASAP or DUI Program | <input type="checkbox"/> Community Diversion | <input type="checkbox"/> State Training Center |
| <input type="checkbox"/> Employer of EAP | <input type="checkbox"/> Incentive Program | <input type="checkbox"/> State MH Provider |
| <input type="checkbox"/> Health Department | <input type="checkbox"/> Dept. of Juvenile Justice | <input type="checkbox"/> Dept. of Rehabilitative Services |
| <input type="checkbox"/> Non-Hospital Substance Use Provider | <input type="checkbox"/> Social Services – Non TANF Worker | <input type="checkbox"/> Social Services – TANF Worker |

Phone Number of Referral Source: _____ **Date Referral Made:** _____

Demographic Information

What is your race?

- | | |
|--|---|
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Alaskan Native |
| <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Multi-Racial |
| <input type="checkbox"/> Asian | <input type="checkbox"/> African-American & White |
| <input type="checkbox"/> Asian & White | <input type="checkbox"/> American Indian |
| <input type="checkbox"/> Native Hawaiian/Pacific Islander | <input type="checkbox"/> American Indian/Alaska Native & African American |
| <input type="checkbox"/> American Indian/Alaska Native & White | <input type="checkbox"/> Other |

Are you of Hispanic Origin?

- Not of Hispanic Origin
 Cuban
 Mexican
 Puerto Rican
 Hispanic, Origin Not Known
 Other Hispanic Origin

If female, are you currently pregnant?

- Yes
 No

If female, living with dependent children ages 0-17?

- Yes
 No
 Unknown

Current Legal Status: (continued on next page)

- | | |
|---|---|
| <input type="checkbox"/> Voluntary | |
| <input type="checkbox"/> Involuntary - Civil | <input type="checkbox"/> Involuntary – Juvenile Court |
| <input type="checkbox"/> Treatment Ordered – Parole | <input type="checkbox"/> Involuntary – Criminal |

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- | | |
|--|--|
| <input type="checkbox"/> Treatment Ordered – Conditional Release | <input type="checkbox"/> Involuntary – Criminal NGRI |
| <input type="checkbox"/> Treatment Ordered – Probation | <input type="checkbox"/> Involuntary – Criminal Sex Offender |
| <input type="checkbox"/> Treatment Ordered – Diversion | <input type="checkbox"/> Treatment Ordered – Parole |

Have you been arrested within the last 30 days? Yes No If "Yes", how many times? _____

In what type of residence do you live?

<input type="checkbox"/> Private Residence/School Dorm	<input type="checkbox"/> Foster Home/Family Sponsor
<input type="checkbox"/> Community Residential (Group Home)	<input type="checkbox"/> Boarding Home
<input type="checkbox"/> Homeless/Homeless Shelter	<input type="checkbox"/> Hospital
<input type="checkbox"/> Nursing Home/Physical Rehab	<input type="checkbox"/> Licensed Adult Care Residence (ACR)
<input type="checkbox"/> Local Jail or Detention	<input type="checkbox"/> Residential Treatment/Alcohol & Drug Rehab
<input type="checkbox"/> State Correctional Facility	<input type="checkbox"/> Shelter
<input type="checkbox"/> Juvenile Detention Center	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Other Institutional Setting	

What is your preferred language? English Spanish ASL Other: _____

Behavioral Health Inpatient Treatment History

Have you ever been admitted to a State Treatment Facility? Yes No
Have you had multiple inpatient hospitalizations for MH or SA treatment? Yes No
What is the name of the last facility in which you received treatment? _____
Date discharged: _____

Contacts	Phone
Emergency Contact (specify relationship) <input type="checkbox"/> None	
Legal Guardian (if Guardian, please submit a copy of the Court Order) <input type="checkbox"/> None	
Former Mental Health/Substance Use Provider (LCSW, LPC, Psychologist, Psychiatrist) <input type="checkbox"/> None	
Authorized Representative <input type="checkbox"/> None	
Parole/Probation Officer <input type="checkbox"/> None	
Primary Care Doctor <input type="checkbox"/> None	
Interpreter <input type="checkbox"/> None	
Other <input type="checkbox"/> None	

Medical Information

Date of last physical: _____
Do you have medical insurance? Yes No Medicare Medicaid Other carrier _____
Subscriber Name: _____ **Subscriber Date of Birth:** _____
Subscriber SSN: _____

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Allergies:	Medication?	Reaction & Severity
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Problems With:		
Vision:		Describe
<input type="checkbox"/> No problems		<input type="checkbox"/> Okay because of glasses, contacts, or surgery <input type="checkbox"/> Blind <input type="checkbox"/> Other: _____
Walking:		
<input type="checkbox"/> No problems		<input type="checkbox"/> I prefer to walk with someone helping me <input type="checkbox"/> I use a wheelchair by myself <input type="checkbox"/> I walk with a cane, walker, or other device <input type="checkbox"/> I use a wheelchair that someone else pushes <input type="checkbox"/> Other: _____
Hearing:		
<input type="checkbox"/> No problems		<input type="checkbox"/> I wear a hearing aid and can hear normally <input type="checkbox"/> I have some trouble hearing <input type="checkbox"/> I am deaf <input type="checkbox"/> Other: _____
Do you need someone to help you communicate? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____
Do you have an Advanced Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you need any other accommodations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____
Medical Conditions:	When?	Please describe
<input type="checkbox"/> Recent physical complaints		
<input type="checkbox"/> Recent medical complaints		
<input type="checkbox"/> Communicable diseases like Hepatitis, TB, HIV, STD, or MRSA		
<input type="checkbox"/> Nutritional Issues		
<input type="checkbox"/> Serious/Chronic Conditions of Self or Family Member		
<input type="checkbox"/> Restrictions on Physical Activities		
<input type="checkbox"/> Past Serious Illnesses and/or Injuries		
<input type="checkbox"/> Doctor Diagnosed Brain Injury		
<input type="checkbox"/> Past Hospitalizations		
<input type="checkbox"/> Use of Alternative Health Treatments (Acupuncture, etc)		
Height: _____ Weight: _____	Sexually Active? <input type="checkbox"/> Yes <input type="checkbox"/> No	Uses Birth Control? <input type="checkbox"/> Yes <input type="checkbox"/> No