HANOVER COUNTY COMMUNITY SERVICES BOARD
INFORMATION FORM

What Brings You Here Today?

First Name:		**Middle Name:**	**Last Name:**
Preferred Name:	**Gender:** ☐ Male ☐ Female	**Gender Identity:** ☐ Male ☐F-to-M ☐ Other ☐ Female ☐M-to-F ☐Decline	**Email Address:**
Address:		**City and State:**	**Zip Code:**
In what County do you live? ☐ **Hanover** ☐ **Other:** _____		**DOB:**	**SSN:**
Home Phone:		**Work Phone:**	**Cell Phone:**

Marital Status (or that of parent/guardian, if minor):
- ☐ Single
- ☐ Married
- ☐ Living with Significant Other
- ☐ Divorced, Separated, or Widowed

Family Size (including self, spouse/significant other, and children under age 18 living in the household)**:** _____

Responsible Party (for billing purposes**):**

_____

Employment Status:

Current Employer, if any: _____

- ☐ Full Time
- ☐ Student
- ☐ Retired
- ☐ Employment Program/Supported Employment
- ☐ Unemployment Not Seeking Job
- ☐ Part Time
- ☐ Homemaker
- ☐ Not in Labor Force – In Institution
- ☐ Not in Labor Force – Sheltered Employment Setting
- ☐ Not In Labor Force – Disabled
- ☐ Unemployed Seeking Job

Educational Level:

- ☐ None
- ☐ Special Education (self-contained only)
- ☐ Pre-School, Head-Start
- ☐ Kindergarten
- ☐ Grade 1
- ☐ Grade 2
- ☐ Grade 3
- ☐ Grade 4
- ☐ Grade 5
- ☐ Grade 6
- ☐ Grade 7
- ☐ Grade 8
- ☐ Grade 9
- ☐ Grade 10
- ☐ Grade 11
- ☐ Grade 12/GED
- ☐ Vocational Education
- ☐ College: Freshman
- ☐ College: Sophomore
- ☐ College: Junior
- ☐ College: Senior
- ☐ Graduate/Professional Prog.

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School Attendance Status:
Current School, if any: _____

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

Military Status:

☐Armed Forces on Active Duty
☐Armed Forces Reserve
☐National Guard
☐Armed Forces or National Guard Retired
☐Armed Forces or National Guard Discharged
☐Armed Forces or National Guard Dependent Family Member
☐Not Applicable/None

Military Start Year:_____**End Year:** _____

Referral Source:

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

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

Demographic Information

What is your race?

☐Black/African American
☐White/Caucasian
☐Asian
☐Asian & White
☐Native Hawaiian/Pacific Islander
☐American Indian/Alaska Native & White
☐Alaskan Native
☐Multi-Racial
☐African-American & White
☐American Indian
☐American Indian/Alaska Native & African American
☐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

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Current Legal Status:

☐ Voluntary
☐ Involuntary - Civil
☐ Treatment Ordered – Parole
☐ Treatment Ordered – Conditional Release
☐ Treatment Ordered – Probation
☐ Treatment Ordered – Diversion
☐ Involuntary – Juvenile Court
☐ Involuntary – Criminal
☐ Involuntary – Criminal NGRI
☐ Involuntary – Criminal Sex Offender
☐ 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?

☐ Private Residence/School Dorm	☐ Foster Home/Family Sponsor
☐ Community Residential (Group Home)	☐ Boarding Home
☐ Homeless/Homeless Shelter	☐ Hospital
☐ Nursing Home/Physical Rehab	☐ Licensed Adult Care Residence (ACR)
☐ Local Jail or Detention	☐ Residential Treatment/Alcohol & Drug Rehab
☐ State Correctional Facility	☐ Shelter
☐ Juvenile Detention Center	☐ Other: _____
☐ 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) ☐ None	
Legal Guardian (if Guardian, please submit a copy of the Court Order) ☐ None	
Former Mental Health/Substance Use Provider (LCSW, LPC, Psychologist, Psychiatrist) ☐ None	
Authorized Representative ☐ None	
Parole/Probation Officer ☐ None	
Primary Care Doctor ☐ None	
Interpreter ☐ None	
Other ☐ None	

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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:

Allergies:	Medication?	Reaction & Severity
	☐Yes ☐No	
	☐Yes ☐No	
	☐Yes ☐No	

Problems With:	Describe
Vision: ☐No problems	☐Okay because of glasses, contacts, or surgery ☐Blind ☐Other: _____
Walking: ☐No problems	☐I prefer to walk with someone helping me ☐I use a wheelchair by myself ☐I walk with a cane, walker, or other device ☐I use a wheelchair that someone else pushes ☐Other: _____
Hearing: ☐No problems	☐I wear a hearing aid and can hear normally ☐I have some trouble hearing ☐I am deaf ☐Other: _____
Do you need someone to help you communicate? ☐Yes ☐No	**Do you need an interpreter?** ☐Yes ☐No If yes, describe: _____
Do you have an Advanced Directive? ☐Yes ☐No	**Do you need any other accommodations?** ☐Yes ☐No If yes, describe: _____

Medical Conditions:	When?	Please describe
☐Recent physical or medical complaints		
☐Communicable diseases like Hepatitis, TB, HIV, STD, or MRSA		
☐Nutritional Issues		
☐Serious/Chronic Conditions of Self or Family Member		
☐Restrictions on Physical Activities		
☐Past Serious Illnesses, Injuries, or Hospitalizations		
☐Doctor Diagnosed Brain Injury		
☐Use of Alternative Health Treatments (Acupuncture, etc)		
Height: _____ **Weight:** _____	**Sexually Active?** ☐Yes ☐No	**Uses Birth Control?** ☐Yes ☐No