Hanover County Community Services Board
Information Form

What Brings You Here Today?				
First Name	**Middle Name**	**Last Name:**	**Date of Birth:**	**SSN:**
Name You Preferred to be Called:		**Parent's First & Last Name, if applicable:**		
Address:		**City and State:**		**Zip Code:**
In what County do you currently live? ☐ **Hanover** ☐ **Other:**_____		**Medical Insurance:** **Do you have insurance?** ☐ **Yes** ☐ **No;** ☐ **Medicare** ☐ **Medicaid** ☐ **Other carrier** _____**?**		
Home Phone:	**Work Phone:**		**Cell Phone:**	
Gender: ☐ **Male** ☐ **Female**	**If female, are you currently pregnant?** ☐ **Yes** ☐ **No**		**If female, living with dependent children ages 0 – 17?** ☐ **Yes** ☐ **No** ☐ **Unknown**	
May we send you appointment reminders? ☐ **Yes** ☐ **No** **If yes,** ☐ **By text?** ☐ **By email?**	**Text to:** **Email to:**		**What is your preferred language?** ☐ **English** ☐ **Spanish** ☐ **ASL** ☐ **Other:**_____	
Name of Emergency Contact ☐ **None**	**Emergency Contact Relationship:**		**Emergency Contact Phone:**	
Primary Care Doctor: ☐ **None** **Phone:**			**Date of Last Physical:**	
Name of Former MH/SUD Provider (LCSW, LPC, Psychologist, Psychiatrist) ☐ **None** **Phone:**				

Contacts	Phone
Legal Guardian (If Guardian, please submit a copy of the Court Order) ☐ **None**	
Authorized Representative ☐ **None**	
Parole/ Probation Officer ☐ **None**	
Rep Payee ☐ **None**	
Interpreter ☐ **None**	
Other ☐ **None**	

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

Problems With:	Describe
Vision: ☐ No problems	☐ Okay because of glasses, contacts or surgery ☐ Blind ☐ Other – Please Explain: _____
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 – Please Explain:
Hearing: ☐ No Problems	☐ I wear a hearing aid and can hear normally ☐ I have some trouble hearing ☐ I am deaf ☐ Other – Please Explain: _____

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 Complaints		
☐ Recent Medical Conditions		
☐ 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 and/or Injuries		
☐ Doctor Diagnosed Brain Injury		
☐ Past Hospitalizations		
☐ Use of Alternative Health Treatments (Acupuncture, etc)		

Height:_____ Weight:_____	Sexually Active? ☐ Yes ☐ No	Uses Birth Control? ☐ Yes ☐ No

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: _____

Demographic Information

What is your race?		Are you of Hispanic Origin?
☐ Black/African-American	☐ Other	☐ Not of Hispanic Origin
☐ Alaskan Native	☐ African-American & White	☐ Cuban
☐ White/Caucasian	☐ Native Hawaiian/Pacific Islander	☐ Mexican
☐ Multi-Racial	☐ American Indian	☐ Puerto Rican
☐ Asian	☐ American Indian/Alaska Native & White	☐ Hispanic, Origin Not Known
☐ Asian & White	☐ American Indian/Alaska Native & African American	☐ Other Hispanic Origin

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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
- ☐ Local Jail or Detention
- ☐ Other Institutional Setting
- ☐ Licensed Adult Care Residence (ACR)
- ☐ Nursing Home/Physical Rehab
- ☐ Residential Treatment/Alcohol & Drug Rehab
- ☐ State Correctional Facility
- ☐ Shelter
- ☐ Hospital
- ☐ Other:_____

Employment Status

Current Employer, if any:

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

Military Status:

- ☐ None ☐ Active Duty
- ☐ Reserves ☐ Discharged
- ☐ National Guard
- ☐ Dependent of Military Parent

Military Start Year: _____

Military End Year: _____

Education Level

- ☐ None
- ☐ Special Education
- ☐ 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 Program

Current School, if any:

_____

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

Current Legal Status:

- ☐ Voluntary
- ☐ Involuntary-Civil
- ☐ Involuntary Correctional Institution
- ☐ Involuntary-Ordered
- ☐ Involuntary-Juvenile Court
- ☐ Involuntary-NGRI
- ☐ Conditional Release – NGRI
- ☐ Court Ordered – Parole
- ☐ Court Ordered- Probation
- ☐ Court Ordered-NGRI Conditional Release
- ☐ Court Ordered – Diversion

Have you been arrested within the last 30 days? ☐ Yes ☐ No

If "Yes" how many times?

_____

Referral Source:

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

Phone # of Referral Source:_____ Date Referral Made:_____