First Name | Middle Name | Last Name | Maiden Name

☐ Male ☐ Female

Date of Birth (mo/day/year) | Age | Social Security #

Has Paper File ☐ Yes ☐ No

Drivers License # | State | Medicaid #

Street Address | City | Zip Code

☐ Alaskan Native
☐ American Indian
☐ Asian
☐ Other Single Race
☐ Pacific Islander
☐ Two or More Races
☐ Hispanic / Latino
☐ Black
☐ White / Caucasian

Special Needs

☐ DRC ☐ County Jail ☐ Interim Group
☐ West Jordan ☐ ☐

Sexual Orientation: Religious Preference:

English Fluency: Preferred Language:

Other Language: Interpreter Needed:

Veteran Status:

( ) Home Phone | ( ) Work Phone | ( ) Cell Phone

( ) Other Phone | ( ) Fax | Preferred Method of Contact

☐ I, _____ agree that Clinical Consultants, LLC can send text messages to the cell number listed above. (check mark the box and initial here: ☐

Email Address

Collateral Contacts:

Actions	First Name	Last Name	Relationship	Phone Number	Contact Auth

First Name | Last Name | Relationship | Gender

Street Address | City | Zip Code

Date of Birth (mo/day/year) | Social Security # | Email Address

( ) Home Phone | ( ) Work Phone | ( ) Cell Phone

( ) Other Phone | ( ) Fax | Preferred Method of Contact

Can Contact Collateral Contact(s) ☐ Yes ☐ No Consent on File ☐ Yes ☐ No

Notes: Legal Guardian ☐ Yes ☐ No

Residence

☐ 24-hour residential care
☐ Adult or Child Foster Home
☐ Institutional (NH, IMD, PSY, IP, VA, ST)
☐ Jail or Correctional Facility
☐ On the street / in a homeless shelter
☐ Other:
☐ Private Residence - Dependent
☐ Private Residence - Independent

Source of Referral at admission:

☐ Self
☐ Family or Friend
☐ Physician or medical facility
☐ Social or community agency
☐ Clergy
☐ Educational System
☐ Courts, law enforcement, correctional agency
☐ Private psychiatric / mental health program
☐ Public psychiatric / mental health program
☐ Private practice mental health professional

HIV / AIDS Positive ☐ Yes ☐ No ☐ Unknown IV Drug User ☐ Yes ☐ No ☐ Current

Presenting Problem

In Client's Own Words

Special Initiative

☐ P-Justice Reinvestment Initiative - ISP
☐ Acquired Brain Disorders
☐ Adult with Organic Disorder w/o SED
☐ Adult with Severe and Persistent Mental Illness

Inter-Agency Service

☐ Child Protective Services (OCS) ☐ Developmental Disabilities
☐ Court / Legal Interface ☐ Domestic Violence

Pregnant ☐ Yes ☐ No _____ Due Date, if Pregnant

Domains

☐ Substance Abuse ☐ Recovery Support Services (RSS)
☐ Mental Health

Profile

☐ Codependent / Collateral ☐ Co-occurring SA and MH Problem ☐ # of Days on Waitlist
☐ Medication Assisted Tx ☐ SMI / SED Status ☐ # of Prior SA Tx Episodes

# of times the client has attended a self-help program in the 30 days preceding the date of admission to treatment services. Includes attendance at AA, NA, and other self-help / mutual support groups focused on recovery from substance abuse and dependence.

☐ Previous MH Tx ☐ Previous MH Tx at UT State Hospital
☐ Previous MH Tx at this Health Center ☐ Atypical Medication Used (fill out space below)
☐ Recovery Capital Score _____ _____

Enrolled in Education ☐ Yes ☐ No Education Status: _____

Financial / Household

Current Employment Status _____ Primary Income Source _____
Funding Source _____ Client Health Insurance _____
Marital Status _____ Living Arrangement _____
Client's Monthly Gross _____ Household Monthly Income _____
Medicaid Eligibility Determined _____ Expected Payment _____
# of People Living with Client, Including Client _____ # of Children Under 18 Living/Not Living with Client _____

Legal

Compelled to Tx _____ Criminogenic Risk _____
Drug Court Participation _____ Mental Health Legal Status _____
# of Arrests in Past 30 Days _____ # of Arrests in Past 6 months _____

Number of Arrests in the Past 6 months due to:

DWI / DUI _____ Crimes Against Property _____ Crimes Against Persons _____

Other SA Offenses _____ Other Offenses _____
e.g. Prostitution / Sex / Solicitation, Public Nuisance, Traffic Offenses

☐ 180 Day Commitment ☐ 30 Day Commitment
☐ 60 Day Commitment ☐ Case Pending

Substance Abuse

Rank	Substance	Severity	Frequency	Method	Detailed Drug Code
Primary					
Secondary					
Tertiary					

At What age did the client FIRST use the substances indicated above: Primary _____ Secondary _____ Tertiary _____
(if unknown enter "97")

# of DAYS since LAST use of the substances indicated above: Primary _____ Secondary _____ Tertiary _____

Tobacco / Nicotine

Have you ever used Tobacco / Nicotine Products? ☐ Yes ☐ No

Are you a current smoker: ☐ Yes ☐ No Age you began smoking: _____

In the past 30 days, what tobacco / nicotine product did you use most frequently? _____

Other (Please describe): _____

In the past 30 days, how often did you use tobacco / nicotine products? _____

Primary _____ Effective Date _____

Secondary _____ Expiration Date _____

Tertiary _____

GAF Score _____ **Diagnosing Clinician** _____

	Code	Description	Comments	Principal
Behavioral Diagnosis				

	Code	Description	Comments	Principal
Medical Diagnosis				

	Code	Description	Comments	Principal
Psychosocial Diagnosis				