



# WELLNESS, INX

913 W. Holmes, Ste. 275, Lansing, MI 48910

Submit

**Date of Assessment** \_\_\_\_\_

**Time Start** \_\_\_\_\_ **am/pm** **End** \_\_\_\_\_ **am/pm** **Court (if applicable)** \_\_\_\_\_

**Referral Source (Circle):** Walk –In, Agency, Court, Other \_\_\_\_\_

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## Section 1: Locator Information

Client name \_\_\_\_\_, \_\_\_\_\_  
Last name First name

Current address: \_\_\_\_\_

City, \_\_\_\_\_ State, \_\_\_\_\_ Zip code

Phone number to reach you? (\_\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_ Preferred contact: email txt phone

### EMERGENCY CONTACT(S) Number:

# 1 (\_\_\_\_\_) \_\_\_\_\_ #2 (\_\_\_\_\_) \_\_\_\_\_

#1 Full name: \_\_\_\_\_ Relationship \_\_\_\_\_

#2 Full name: \_\_\_\_\_ Relationship \_\_\_\_\_

What is the name of the place you work or plan to work? \_\_\_\_\_

### Military Service

Most Recent military service era \_\_\_\_\_ (WWII, Vietnam, etc.)

Branch served in? \_\_\_\_\_ (Army, Air Force, Marines, Navy, National Guard, etc.)

Family military services? \_\_\_ Yes \_\_\_ No

Client/family enrolled in/connected to VA/veterans resource/other & service organizations

\_\_\_ Yes \_\_\_ No

## Section 2: Health Information

Health Insurance: \_\_\_\_\_ PCP: \_\_\_\_\_

Last Physical (mm/yy): \_\_\_\_\_ Phone Number: \_\_\_\_\_

Food Stamps: \$ \_\_\_\_\_ SSI/SSD: \$ \_\_\_\_\_

Cash assistance: \$ \_\_\_\_\_ Month Employment Income: \$ \_\_\_\_\_

Have you ever had an MH dx?: No Yes What?: \_\_\_\_\_

MH provider: \_\_\_\_\_

MMMP Card?: No Yes No. & Expiration Date: \_\_\_\_\_

Are you taking any medications, herbals or supplements? No Yes (Fill out med form)

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## Section 3: Demographic Information

DOB \_\_\_\_\_ Soc Number \_\_\_\_\_ Gender: \_\_\_\_\_

*(Interviewer, verify this number with a social security card. Criminal Record Search)*

Gender identification, please check: Male \_\_\_\_\_ Female \_\_\_\_\_

In what country were you born? \_\_\_\_\_

If not born in the U.S., how many years have you lived in the U.S.? \_\_\_\_\_ years

What race do you consider yourself? \_\_\_\_\_ Hispanic Ethnicity? Yes No

What language do you usually speak? \_\_\_\_\_

Do you have a particular religion you follow? \_\_\_\_\_

Have you been in a controlled environment in the past 30 days like a hospital or jail (not a shelter)? NO YES

*If yes, please tell me which controlled environment(s) you have been in and how many days you have spent in that environment in the previous 30 days: \_\_\_\_\_*

***If Female ask How*** many times have you been pregnant? \_\_\_\_\_ times.

Are you pregnant now? NO YES

***If Male ask*** "How many pregnancies have you been responsible for?"

\_\_\_\_\_ pregnancies

How many of those pregnancies resulted in a live birth? \_\_\_\_\_ pregnancies

How old were you when the *first* baby was born? \_\_\_\_\_ years old

How many children do you have? \_\_\_\_\_ children

Nicotine Use: Smoker: \_\_\_ Vapor: \_\_\_ E-Cig: \_\_\_ Chew: \_\_\_