COUNSELING CENTER @ MHA

CLIENT INFORMATION FORM

(Please Print)

PATIENT INFORMATION

Client's Legal Name Last:	First:	Middle:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital status (circle one) ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid

Race ☐White ☐Black ☐ Asian ☐ Native American ☐Hispanic ☐Other ☐ Declined	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Home phone no.:	Other phone no.:

City:	State:	ZIP Code:	Social Security Number

Parent/Guardian or Financially Responsibly Party	Relationship to Patient

Street address:	Home phone no.: ( )	Other phone no.: ( )

City:	State:	ZIP Code:	Social Security Number

May we state agency name when contacting you by phone or email? ☐ Yes ☐ No	I give my permission to be added to MHA's mailing list. ☐ Yes ☐ No

The Counseling Center uses an automated appointment reminder system to verify appointments. Clients who opt out will not receive reminder calls for appointments. Do you want to receive reminder calls?

☐ Yes ☐ No Which number?

INSURANCE INFORMATION

❑ Check if your information has already been submitted

Please indicate primary insurance

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Other

Name of Company		
Subscriber's name:	Group no.:	Policy no.:
DOB:	Social Security Number	

Secondary insurance ❑ I have no other insurance (This box must be checked if no secondary insurance company is used.)

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Other

Name of Company		
Subscriber's name:	Group no.:	Policy no.:
DOB:	Social Security Number	

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
Address	City	State	Zip

Hospital of Choice
☐ Wesley ☐ St. Francis ☐ St. Joe ☐ Other _____

PRIMARY CARE PHYSICIAN

Name:	Office No. ( )	Fax No. ( )

Address	City	State	Zip

CASE MANAGEMENT (OTHER THAN MHA)

Name of Agency

Name:	Phone No.	Fax No.

Address	City	State	Zip

Role	Email

SCHOOL CONTACT

Name of School	Grade

Name:	Phone No.	Fax No.

Address	City	State	Zip

Role	Email

LEGAL CONTACT (PROBATION OFFICER, ATTORNEY, ETC.)

Name of Agency

Name:	Phone No.	Fax No.

Address	City	State	Zip

Role	Email

The above information is true and accurate. If any information changes, I will notify Counseling Center front office staff.

Signature	Date

Please complete the follow questions to determine if you qualify for any special payment options.	
Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility?	☐ Yes ☐ No
Are you entitled to Medicare?	☐ Yes ☐ No
Do you currently receive Health Insurance through your Employer, Former Employer (retiree or COBRA Policy), of Self-employment?	☐ Yes ☐ No
Do you currently receive Health Insurance through a spouse of family member?	☐ Yes ☐ No
Are you a Kansas resident (have a Kansas ID or a utility bill with address)?	☐ Yes ☐ No
Are you a citizen of the United States?	☐ Yes ☐ No
Household Size	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8+
Household Income	

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME *(Last, First, M.I.):*	**DOB:**
PRIMARY CARE PHYSICIAN:	**DATE OF LAST PHYSICAL EXAM:**

PERSONAL HEALTH HISTORY

ARE YOU CURRENT ON YOUR IMMUNIZATIONS ☐ Yes ☐ No ☐ Unknown

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

	Past	Current	N/A	Family History		Past	Current	N/A	Family History
High Blood Pressure	☐	☐	☐	☐	Anxiety	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	Learning Problems	☐	☐	☐	☐
Menstrual Pain	☐	☐	☐	☐	Attention Deficit/ Hyperactivity	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	Schizophrenia	☐	☐	☐	☐
Chronic Pain	☐	☐	☐	☐	Bipolar Disorder	☐	☐	☐	☐
Stomach/Bowel Problems	☐	☐	☐	☐	Depression	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Sleep Disorder	☐	☐	☐	☐
Sexual Problems	☐	☐	☐	☐	Eating Disorder	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	Suicide Attempts/ Thoughts	☐	☐	☐	☐

Are you having any thoughts of harming yourself of someone else? ☐ YES ☐ NO
Are you in danger of harm from someone else? ☐ YES ☐ NO
Are you hearing/seeing things others around you can't hear or see? ☐ YES ☐ NO

Comments:

HAS CLIENT BEEN HOSPITALIZED IN THE PAST YEAR? ☐ **YES** ☐ **NO**

Date	Reason	Hospital

Tobacco History

Do you use tobacco products ☐ Never ☐ No ☐ Yes

If yes, are you interested in quitting? ☐ No ☐ Yes

CURRENT MEDICATIONS

Name the Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS

Name the Drug	Reaction You Had

MHA DOES NOT PRESCRIBE BENZODIAZAPINES (BENZOS) IN NEW CLIENTS. BENZODIAZAPINES ARE A CLASS OF MEDICATION THAT INCLUDES VALIUM (DIAZEPAM), ATIVAN (LORAZAPAM), XANAX (ALPRAZOLAM) AND KLONOPIN (CLONAZEPAM) AND SEVERAL OTHERS.

Are you currently taking a benzodiazepine medication? If yes, please list those medications below.	Yes ☐	No ☐

HEALTH GOALS

Is there anything you would like to change about your health?	Yes ☐	No ☐
Please explain:		