Client Intake Sheet

Appointment Date: _____ Client #:- _____

Options Counseling and Family Services

Date :

Client Legal Name: Last First Middle
Client Date of Birth: Select Date
Chosen Name:

Birth/Maiden Name: Social Security #:

Pronoun: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other

Sex at the time of Health Plan enrollment: ☐ Male☐ Female☐ Other

Gender ☐ Male☐ Female☐ Genderqueer (neither male or female)

Options Location: Options Counseling and Family Services Location: ▼

Primary Language: **Interpreter Needed?** ☐ Langue☐ ASL

Primary - Physical Address :

Primary - Mailing Address: ☐ Same as physical

Okay to send mail from Options? ☐ Yes☐ No

Alternate - Physical Address :

Alternate - Mailing Address: ☐ Same as physical

Okay to send mail from Options? ☐ Yes☐ No

Email Address:
Okay to send email from Options ☐ Yes☐ No

Primary Phone #:
Name: **Relationship to Client:**
Type of Phone ☐ Home☐ Cell☐ Work

OK to ID : ☐ Yes☐ No
Ok to text : ☐ Yes☐ No
Appt. Reminder to this # ☐ Calls☐ Text

Secondary Phone #:
Name: **Relationship to Client:**
Type of phone ☐ Home☐ Cell☐ Work

Ok to ID ☐ Yes☐ No
Ok to text ☐ Yes☐ No

Guardian 1 Phone: (if applicable):
Name: **Relationship to Client:**
Address:
Okay to send mail from Options? ☐ Yes☐ No

Type of phone ☐ Cell☐ Home☐ Work
Ok to ID ☐ Yes☐ No
Ok to Text ☐ Yes☐ No

Guardian 2 Phone: (if applicable):
Name: **Relationship to Client:**
Address:

Okay to send mail from Options? ☐ Yes☐ No

Type of phone ☐ Cell☐ Home☐ Work
Ok to ID ☐ Yes☐ No
Ok to Text ☐ Yes☐ No

Emergency Contact Phone #:
Name: **Relationship to Client:**
Type of phone ☐ Home☐ Cell☐ Work

Ok to ID ☐ Yes☐ No
Ok to Text ☐ Yes☐ No

Client Support System:

Spouse \ Partner : **Phone :**

Other Household Members (Siblings, Roommates):
Name/Relationship to Client : **Age:**
Name/Relationship to Client : **Age:**
Name/Relationship to Client : **Age:**
Name/Relationship to Client : **Age:**

Primary Care Doctor: **Phone :**
Clinic Name : **Fax :**
Dental Provider : **Phone :**

<u>Other Agencies, Case Workers, or Health Care Providers Involved:</u>

Contact Name : **Phone :**
Agency/Program : **Fax :**

Contact Name : **Phone :**
Agency/Program : **Fax :**

Payment Arrangements:

Primary Insurance _____ Ins Phone # _____
ID : _____ Group # : _____
Policy Holder Name: _____ DOB : _____ Phone : _____

Secondary Insurance _____ Phone : _____
ID : _____ Group # : _____ Ins Phone # _____
Policy Holder Name: _____ DOB : _____

I have made other payment arrangements

☐ Self Pay
☐ Sliding Scale
☐ Other
_____

Client Demographic Data:

It is the policy of Options Counseling and Family Services to be non-discriminatory in the delivery of services to clients without regard to race, color, religion, national origin, age, gender, disability, source of income, gender identity or expression, and/or sexual orientationOptions is required to request the following information for Oregon Department of Human Services for the Measures and Outcomes Tracking System (MOTS). This data is collected and used to determine funding levels and effectiveness of mental health programs in our community.

Race (Please check from the following):
☐ White☐ Alaskan Native☐ Other Single Race☐ American Indian☐ Asian☐ Two or More Unspecified Races☐ Black / African American ☐ Native Hawaiian / other Pacific Islander

Ethnicity (Please check from the following):
☐ Not of Hispanic Origin☐ Hispanic – No Specific Origin☐ Other Specific Hispanic ☐ Puerto Rican☐ Cuban☐ Mexican☐ Unknown

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Marital Status (Please check from the following):
☐ Never Married☐ Married☐ Widowed☐ Divorced☐ Separated☐ I prefer not to respond

Are you a Veteran?:
☐ Yes, Current/Former Active Duty Military☐ Yes, Current/Former Guard/Reserve ☐ No, But Current/Former Guard/Reserve Military ☐ No

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Tobacco Use (in the last 90 days): ☐ Yes☐ No☐ I Prefer Not to Share

Substance Use (in the last 90 days):
(alcohol or non-prescribed medications) ☐ Yes☐ No☐ I Prefer Not to Share

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Employment Status of the Client (Please check from the following): ☐ I Prefer Not to Share☐ Full Time (over 35 hours/week)☐ Student☐ Sheltered/Non-Competitive Employment☐ Part Time (under 35 hours/week)☐ Retired☐ Not in the Labor Force☐ Unemployed – Seeking Employment☐ Disabled☐ Other Classification (ex. Volunteers)☐ Homemaker☐ Hospital or Institutional Resident

Highest Grade Completed : _____ **Are you currently enrolled in school/training?**: ☐ Yes☐ No

School Name: _____ **Current Grade :** _____

Living Arrangements (Please check from the following):
☐ Private Residence☐ Residential Facility (BRS)☐ Supported Housing – Scattered Site☐ Private Residence (at home)☐ Residential Facility (CSEC)☐ Supported Housing – Congregate Setting☐ Private Residence (with relative)☐ Residential Facility (PRTS)☐ Private Residence (with non-relative)☐ Residential Facility (SCIP/SAIP) ☐ Residential Facility (SRTF -YAT)☐ Oxford Home☐ Transient/Homeless☐ Secure Residential (SRTF Adult)☐ Alcohol/Drug Free Housing☐ Foster Home☐ Residential SubAcute Facility☐ Supported Housing – Other Type☐ Jail☐ Room & Board-Independent Living Facility☐ Residential Facility/Group Home ☐ Residential Facility (SUD) ☐ Prison ☐ Other

_____

Estimated *Monthly Household* Income: $ _____

☐ Prefer Not to Share

Primary Source of Income (Please check from the following):
☐ I Prefer Not to Share☐ Wages/Salary☐ Retirement/Pension SSI☐ Other☐ Public Assistance☐ Disability/SSDI☐ None

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Dependents (Include the total number of persons, including the client, that are supported by the household income) :
Adults (include minors living independently) : # _____
Children (include minors for which child support is paid out of this income): # _____

Tribal Affiliation (Please check from the following):
☐ Not Applicable ☐ Confederated Tribes of Siletz☐ Cow Creek Band of Umpqua Indians☐ Burns Paiute Tribe ☐ Confederated Tribes of the Umatilla☐ Klamath Tribes☐ Confederated Tribes of Coos, Lower Umpqua & Siuslaw ☐ Confederated Tribes of Warm Springs ☐ Confederated Tribes of Grand Ronde☐ Coquille Indian Tribe☐ Other

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Are you currently pregnant?: ☐ Yes☐ No☐ Not Applicable/Male☐ I Prefer Not to Share

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Referred From – How did you hear about Options? ☐ Child Welfare☐ Vocational Rehabilitation☐ Aging and People with Disabilities☐ Local Mental Health Authority☐ Developmental Disability Services☐ Community Mental Health Program☐ School / Community ☐ Housing☐ Employment Services

Personal Support System: ☐ Self☐ Family / Friend☐ Employee Assistance Program☐ Advocacy Group☐ Attorney
Health Care Providers: ☐ Community Substance Abuse Provider☐ Community Mental Health Provider☐ Coordinated Care Organization☐ State Psychiatric Facility☐ Private Health Professional (ex PCP, PHD, Hospital, Health Home)
Justice System: ☐ Federal Court☐ Circuit Court☐ Justice Court☐ Jail☐ Municipal Court☐ Parole – including Juveniles☐ Police or Sheriff☐ Psychiatric Review Board☐ Probation - including Juveniles☐ State Correctional Institution☐ Federal Correctional Institution☐ Integrated Treatment Court☐ Juvenile Justice System/OYA
Other : ☐ Crisis/Helpline☐ Internet/Media☐ Other☐ None☐ I Prefer Not to Respond

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Comments / Questions :

X

Signature Certificate

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September 29, 2021 1:10 pm PDT	Options Intake - intake@options.org added by Adam Falk - adam.falk@options.org as a CC'd Recipient Ip: 206.192.252.48
October 13, 2021 8:58 am PDT	Options Intake - intake@options.org added by Adam Falk - adam.falk@options.org as a CC'd Recipient Ip: 206.192.252.48

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