Coastal Horizons Center, Inc. **Client Information Form**

Instructions: Print Clearly. Use Black Ink. Draw a **SINGLE LINE** through any mistakes.

LAST Name: | **Today's Date:**

FIRST Name:

MIDDLE Name:

(MAIDEN) Name:

Date of Birth : | **Age:** | **Gender:** ☐Male ☐Female | **SSN:**

Home phone plus area code:

Cell phone plus area code:

Work phone plus area code:

CHC offers automated voice & text reminders for upcoming individual and/or doctor visits.

(Note: Written Authorization for the Use/Disclosure of Protected Health Information is required and standard text rates apply.)

I would like automated reminders using my primary phone:
(choose only ***one***) ☐ Home ☐ Cell ☐ Work

☐ I do **NOT** want automated reminders

Who referred you to Coastal Horizons Center? **(*please mark all that apply*)**

☐ Self	☐ DSS	☐ TASC	☐ Judge/Court	☐ Court Counselor
☐ Family / Friend	☐ Voc Rehab	☐ State P.O.	☐ Private physician	☐ School
☐ Inpatient Facility	☐ SE Center	☐ Federal P.O.	☐ Other:	

Do you have any of the following? (*please mark all that apply*)

Medicaid?	☐ **No**	☐ **Yes**	**If Yes**, type? ________
Medicare?	☐ **No**	☐ **Yes**	**If Yes**, type? ☐ **A only** ☐ **B only** ☐ **A and B**
Health Choice?	☐ **No**	☐ **Yes**	
Private Health Insurance?	☐ **No**	☐ **Yes**	Name: ________

(Note: Written Authorization for the Use/Disclosure of Protected Health Information is required to contact third parties for billing, a copy of your card is required and all services may not be covered by your insurance.)

Is **English** your preferred language? ☐ Yes ☐**No **If No,** list preferred language:

Race:		**Ethnicity:**	**Marital Status:**
☐ Alaskan Native	☐ Native Hawaiian	☐ Cuban	☐ Domestic Partners
☐ American Indian	☐ Pacific Islander	☐ Mexican American	☐ Divorced
☐ Asian	☐ White	☐ Puerto Rican	☐ Married
☐ Black	☐ Other: ____________		☐ Never Married
☐ Multiracial		☐ **None Above**	☐ Separated
			☐ Widowed

Are you your own legal guardian? ☐Yes ☐No

If NO, please write the name of your legal guardian:

How this person is related to you?

What is their primary phone number including area code?

FOR FRONT DESK OFFICE USE ONLY – PLEASE DO NOT WRITE BELOW THIS LINE

Check-In Staff viewed this page as complete: | If Insured, did client sign consents to bill? ☐ Yes ☐ No

If insured, was a copy of the card obtained? ☐ Yes ☐ No

Printed verification of Medicaid coverage/no coverage attached to CI packet - ☐ Yes ☐ No Eligible? ☐ Yes ☐ No

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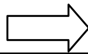 **Print your name:**

FEMALES ONLY:

Are you currently pregnant? ☐ No ☐ Not sure ☐ Yes

If yes, name of Dr. or Office following your care:

IN CASE OF AN EMERGENCY WHO SHOULD WE CONTACT?

Name: Relationship of emergency contact:

Number **include area code**: City/State:

Highest education grade completed: ________ If less than 12th, do you have your GED? ☐ No ☐ Yes

Are you currently enrolled? ☐ No ☐ **Yes

****If yes**, what grade are you currently in? Name of the school:

Employment Status:

☐ Full-time
☐ Part-time
☐ Unemployed - looking
☐ Unemployed - not looking
☐ Currently a student
☐ Receiving Disability Benefits
☐ Receiving Unemployment Benefits
☐ Seasonal work
☐ Home-maker
☐ Retired

When employed, what is your **usual** occupation?

What best describes your current living arrangements?

☐ Alone ☐ With child(ren) ☐ Other relatives ☐ With Parents ☐ Other:

☐ With Spouse ☐ Homeless ☐ Others not related ☐ HARRTS

Physical Address:

P.O. Box (if applicable):

City: **Zip:** **County:**

Mailing Address: ☐ Same **- OR -**

Including yourself, how many people live in your household?

What is your household annual income?

How many times in the last 30 days have you been arrested?

Who is your Primary Care Medical Provider?

Are you a Veteran? ☐ No ☐ Yes

Are you in the Reserves? ☐ No ☐ Yes

Who served in Active Duty? ☐ N/A ☐ Self ☐ Spouse ☐ Partner ☐ Other Significant Person ☐ Child ☐ Parent ☐ Sibling ☐ Grand Parent

Which war? ☐ OIF('03-Present) ☐ OEF('01-Present) ☐ Other War ☐ Non Combat Service Only

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Print your name:

What brings you to us today? What services are you looking for? How may we help you?

Do you require any of the following?

A court ordered evaluation	☐ Yes	☐No	A DWI Assessment?	☐ Yes	☐No
A one time assessment?	☐ Yes	☐No	Counseling specific to a DWI?	☐ Yes	☐No

Medical Information:

Do you have any diagnosed medical conditions or any medical concerns? ☐ No **☐ Yes

**If yes, please list them:

Have you taken any medication ***prescribed to you*** within the last 24 hours? ☐ No **☐ Yes

**If yes, what doctor or clinic is prescribing them?

**If yes, please list CURRENT meds:

Do you have any allergies or hypersensitivities? ☐ No **☐ Yes

**If yes, please list them:

Do you chew or smoke tobacco products ***(circle)***? ☐ No ☐ Yes

Are you receiving help from any other agency(s) or provider(s)? ☐ No **☐ Yes

**If yes, please list them:

Please mark the number of times you have attended any AA, NA or other self-help mutual support groups focused on recovery from substance abuse and dependence in the last 30 days.

☐ No attendance in past month	☐ 4-7 times (about 1x week)	☐ 16-30 times (4x's or more a week)
☐ 1-3 times (less than 1x a week)	☐ 8-15 times (2-3x's week)	☐ Some attendance, frequency unknown

Legal issues:

Do you have any criminal charges pending?	☐ No	☐ Yes	Court Date:	
Do you have any outstanding warrants?	☐ No	☐ Yes	What for?	
Are you on any kind of probation?	☐ No	☐ Yes	☐ Supervised	☐ Unsupervised
Is treatment required by your probation officer?	☐ No	☐Yes	P.O. Name:	
Is this treatment required by the courts?	☐ No	☐Yes	Why?	
Are you currently enrolled in TASC?	☐ No	☐ Yes	Name of TASC Staff?	

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Time arrived:	Time completed:

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