Serving Fayette, Highland, Pickaway, Pike, and Ross Counties

Thank you for choosing Scioto Paint Valley Mental Health Center!

This packet includes all information forms that are needed to enroll you as a new client or to update your existing client account.

Be sure to have the following items ready to be scanned/copied at your appointment:

- DRIVERS LICENSE OR STATE ID CARD
- INSURANCE CARD(S)
- COURT / CUSTODY / GUARDIANSHIP DOCUMENTS
- POWER OF ATTORNEY DOCUMENTS
- RELEASE OF INFORMATION DOCUMENTS

We look forward to seeing you in our clinic!

If you have any questions, problems or concerns our staff members would be more than happy to assist you at the office or by phone.

Kind regards,

SCIOTO PAINT VALLEY MENTAL HEALTH CENTER

# CLIENT DEMOGRAPHIC INFORMATION

**First Name:**_____ **Middle:**_____ **Last:**_____

**Preferred First Name:** _____ **Maiden Name:**_____

**DOB:**_____ **Social Security Number:**_____

**Legal Gender:** ☐ Male ☐ Female

What is your current gender identity?

☐ Identifies as Male
☐ Identifies as Female
☐ Female-to-Male (FTM)/Transgender Male/Trans Man
☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
☐ Genderqueer, neither exclusively male nor female.
☐ Additional gender category or other, please specify.
☐ Choose not to disclose

If other please specify: _____

**Pronouns:** _____

**Address Information:**

Physical Address: _____

City/State/Zip Code: _____

County: _____

Mailing Address: _____

City/State/Zip Code: _____

County: _____

Are We Able To Send You Mail? ☐ Yes ☐ No

**Phone Information:**

Home Phone:_____

Is it Ok To Leave A Message? ☐ Yes ☐ No

Cell Phone:_____

Is it Ok To Leave A Message? ☐ Yes ☐ No

Work Phone:_____

Is it Ok To Leave A Message? ☐ Yes ☐ No

# CLIENT DEMOGRAPHIC INFORMATION

**Race:** _____ **Ethnicity:** _____ **Marital Status:** _____

**Current Employment Status:**

☐ Full Time ☐ Part Time ☐ Disabled ☐ Engaged In A Residential/Hospitalization Program

☐ Homemaker ☐ Student ☐ Volunteer Worker ☐ Inmate In Jail/Prison/Corrections

☐ Retired ☐ Unemployed But Actively Looking For Work ☐ Other Not In Labor Force

**Highest Education Level:** _____ **IEP:** ☐ Yes ☐ No

**Military Status:** ☐ Active ☐ Discharged ☐ Disabled Veteran ☐ No Military Service

**Referred To SPVMHC By:** _____

**Emergency Contact Information:**

Name: _____

Address: _____

Phone Number: _____

Relationship To Client: _____

Legal Guardian: ☐ Yes ☐ No

Name: _____

Address: _____

Phone Number: _____

Relationship To Client: _____

Legal Guardian: ☐ Yes ☐ No

Name: _____

Address: _____

Phone Number: _____

Relationship To Client: _____

Legal Guardian: ☐ Yes ☐ No

# CLIENT DEMOGRAPHIC INFORMATION

**Primary Care Physician Information:**

Name: _____

Address: _____

Phone Number: _____

**Income Information:**

Number In Household: _____ How Many Under 18: _____

Estimated Monthly Income: _____

**Income Is From:** ☐ Wages/Salary ☐ SSI/Disability ☐ Family/Relative ☐ Public Assistance ☐ Retirement/Pension

**Insurance Information:**

Primary Insurance:

Name Of Insurance Provider: _____

Member ID Number: _____

Group Number: _____

Benefits Phone Number: _____

Insurance Mailing Address: _____

_____

Secondary Insurance:

Name Of Insurance Provider: _____

Member ID Number: _____

Group Number: _____

Benefits Phone Number: _____

Insurance Mailing Address: _____

_____

Subscriber Name: _____

**If Information Is For A Child, Please Provide Responsible Party Name And Address:**

Name: _____ Address: _____

**Signature:** _____ **Date:** _____

# GOSH ENROLLMENT/CLIENT VERIFICATION FORM

| Client ID |
|---|
| |

* The purpose of this form is to clarify which county is responsible for adjudicating claims for behavioral health services provided to the client being enrolled. It should be completed and provided to the enrolling board when:
* The county of the treating facility does not match the legal county of residency of the client as noted on the enrollment form (child or adult, out- of -county)
* The physical addresses of the client as noted on the enrollment form does not match the legal county of residence of the client (example: domestic violence shelter case, client temporarily living with relatives, child or adult out-of-county)
* The child's physcial address as noted on the enrollment form does not match the legal custodian's address (child only, in or out-of-county)

**A client's or legal custodian's signature on this form shall be sufficient for documenting residency with the exception of adults who reside in specialized residental facilities or who are committed pursuant to special forensic categories referenced in the residency guidelines.**

| **Please fill the following information:** | | |
|---|---|---|
| **Client is an Adult** ( ) Yes ( ) No | **Client is a Minor** ( ) Yes ( ) No | If YES, Indicate if CHILD is in legal custody of the following: NOTE: (this is not the foster parent) ( ) Parent ( )CSB ( ) DYS ( ) Court ( ) Other (specify) _____ |
| Client Name (Please Print) | | Contact Number |
| DOB | SS# | Gender Circle One: Male Female Other |
| Street Address for Residency Determination | | |
| City, State and Zip for Residency Determination Purposes | | County |
| Name of Legal Custodian Marked Above If a Minor | | County of Legal Custodian |
| If Parent, Address of Parent (if different from client's physical address on enrollment form: | | |
| **Marital Status: (please circle one)** Married Single Never Married Divorced Separated Widowed | | |
| **Ethnicity: (please circle one)** Not of Hispanic Origin Cuban Mexican Puerto Rican Other Hispanic Descent | | |
| **Race: (please circle one)** White Black Bi-Racial American Indian Asian Unknown | | |
| Insurance: Yes _____ No _____ | TOTAL **MONTHLY** HOUSEHOLD INCOME | FAMILY SIZE |
| X | **Signature of Client/Legal Custodian** | **Date:** |

☐ **New Clients** ☐ **Client Update** **Staff Verified:** _____

# SCIOTO PAINT VALLEY MENTAL HEALTH CENTER
## -SELF HEALTH STATUS FORM-

| NAME: | CLIENT ID: |
|---|---|
| FAMILY DOCTOR: | |
| PREFERRED PHARMACY: | |

| DO YOU HAVE ANY OF THESE CONDITIONS OR HABITS? | NO | YES |
|---|---|---|
| AIDS/HIV | | |
| ALCOHOL/DRUG USE | | |
| ARTHRITIS | | |
| ASTHMA | | |
| BLOOD PRESSURE | | |
| CANCER | | |
| CHOLESTEROL | | |
| DEPRESSION | | |
| DIABETES | | |
| EMPHYSEMA/COPD | | |
| HEADACHE/HEART PROBLEMS | | |
| HEPATITIS C | | |
| LIVER PROBLEMS | | |
| SEIZURES/EPILEPSY | | |
| STOMACH ULCER | | |
| TB | | |
| THYROID PROBLEM | | |
| TUMORS | | |
| DO YOU SMOKE? | | |
| DO YOU GET A FLU SHOT? | | |
| ARE YOU OVERWEIGHT? | | |
| DO YOU EXERCISE? | | |

**PLEASE LIST YOUR ALLERGIES:**

**PLEASE LIST YOUR MEDICATION(S):**

(PRESCRIPTIONS & OVER THE COUNTER)

USE THE BACK OF SHEET IF NEEDED

**HOW OFTEN DO YOU HAVE A DRINK CONTAINING ALCOHOL? (CIRCLE ANSWER)**

NEVER MONTHLY OR LESS

2-3 PER WEEK 4+ PER WEEK

**HOW MANY DRINKS CONTAINING ALCOHOL DO YOU HAVE IN A USUAL DAY?**

0-2 3-4 5-6 7-9 10+

**HOW OFTEN DO YOU HAVE 6 + DRINKS ON ONE OCCASION?**

NEVER MONTHLY LESS THAN MONTHLY

WEEKLY DAILY OR ALMOST DAILY

Scioto Paint Valley Mental Health Center
Social History and Needs Assessment

**Date:** **Name:** **Clinic:**

## FAMILY HISTORY

Describe the family in which you grew up (primary caregivers, siblings, birth order):

Describe childhood and adolescence (atmosphere, location, significant events):

Any significant childhood issues that are impacting current presenting problem? ☐ Yes ☐ No

**(Please check all that apply to parents, grandparents, and siblings)**

**History of Mental Illness:** ☐ Yes ☐ No

**History of Substance Abuse:** ☐ Yes ☐ No

**History of Criminal Activity:** ☐ Yes ☐ No

**History of Violent Behavior:** ☐ Yes ☐ No

**History of Medical Problems:** ☐ Yes ☐ No

**Scioto Paint Valley Mental Health Center**
**Social History and Needs Assessment**

## MEDICAL INFORMATION

Have you been compliant with medication instructions in the past? ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No

Number of pregnancies: _____ Have any resulted in "live births"? ☐ Yes ☐ No

Number of live births: _____ Birth Control? ☐ Yes ☐ No

Birth control method: _____

Do you have any special nursing needs? ☐ Yes ☐ No

If yes, specify:

_____

Do you experience limitations due to physical health or disability? ☐ Yes ☐ No

If yes, explain:

_____

Name of personal physician: _____ Phone Number: _____

Treating facility: _____

## INTIMATE RELATIONSHIPS AND CURRENT LIVING SITUATION

Current marital status: ☐ Married ☐ Divorced ☐ Single

If ever married, number of times: _____

If married (or in a significant relationship) more than once, explain the reasons for each divorce or separation:

_____

Describe relationship with current partner:

_____

Sexual issues of concern:

_____

**Scioto Paint Valley Mental Health Center**
**Social History and Needs Assessment**

Current living arrangement:

Number of people, including you, living in the home:

Do you need food, clothing or shelter? ☐ Yes ☐ No

Have you moved in the past two years? ☐ Yes ☐ No

If you have moved, how many times?

Current home atmosphere:

Describe your current living situation:

Are you satisfied with his/her current living situation? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No

If yes, give names and ages, where children live, and describe relationships with children:

## CULTURAL, GENDER, AND SPIRITUAL CONSIDERATIONS

Do you identify with a particular cultural group? ☐ Yes ☐ No

If so, describe the group:

Gender and/or Sexual Orientation Issues: ☐ Yes ☐ No

If so, explain:

Gender Expression: ☐ Male ☐ Female ☐ Other

Primary Religious Affiliation:

Do you have spiritual strengths? ☐ Yes ☐ No Spiritual problems? ☐ Yes ☐ No

Are there cultural, gender, sexual orientation, or spiritual beliefs likely to impact treatment?

## EDUCATIONAL AND DEVELOPMENTAL INFORMATION

Are there any problems of an academic nature? ☐ Yes ☐ No

Are you currently in school/college/training program? ☐ Yes ☐ No

Name and location of school/college/training program:

Highest grade completed:

Were you in special-education classes? ☐ Yes ☐ No ☐ Unknown

Describe school functioning:

Can you read and write? ☐ Yes ☐ No ☐ Unknown

Do you have a history of developmental delay? ☐ Yes ☐ No ☐ Unknown

If yes, specify:

Do you have qualities that could be academic strengths? ☐ Yes ☐ No

## VOCATIONAL INFORMATION

Current employment status:

If employed, how long at current job?

Do you have problems of a vocational nature? ☐ Yes ☐ No

**Scioto Paint Valley Mental Health Center**
**Social History and Needs Assessment**

Are you satisfied with current job? ☐ Yes ☐ No ☐ N/A

Any difficulty performing work or work-like activity? ☐ Yes ☐ No

Please describe the severity/frequency of work problems of any kind:

Work History:

## FINANCIAL STATUS

Source of income received in the last 12 months:

Do you have financial problems? ☐ Yes ☐ No

If yes, explain:

## LEGAL HISTORY

Do you have any past or present legal history or legal involvement? ☐ Yes ☐ No

**If yes, complete this section If no, skip this section** ☐ Information not available

Present legal involvement:

Past legal involvement:

Reasons for last incarceration, when and how long:

Are you currently awaiting charges, trial or sentencing? ☐ Yes ☐ No ☐ N/A

Last arrested for (offense): Date:

**Military Veteran:** ☐ Yes ☐ No

Branch: ☐ Army ☐ Navy ☐ Air Force ☐ Coast Guard ☐ Marines

Discharge: ☐ Honorable ☐ General ☐ Medical ☐ Dishonorable ☐ Other

**Gambling Issues:**

Are you over the age of 12? ☐ Yes ☐ No **(If No, do not answer the following questions)**

In the past 12 months;

Have you been preoccupied with gambling? ☐ Yes ☐ No

Have you needed to gamble with larger amounts of money to get the same feeling?

☐ Yes ☐ No

Have you often gambled longer, with more money or more frequently, than you intended?

☐ Yes ☐ No

Have you made attempts to either cut down, control or stop gambling? ☐ Yes ☐ No

Have you borrowed money or sold anything to get money to gamble? ☐ Yes ☐ No

## CHILDREN OR PERSONS WITH GUARDIANS ONLY

(For use with minor's only)

**Developmental History**

☐ Information not available. **(Proceed to Infant Temperament Section)**

☐ All early developmental issues are reported within normal limits. **(Proceed to Infant Temperament Section)**

☐ There are some developmental issues worth noting. **(Please complete all items below that you answer 'yes' to and include age of onset)**

Were there complications with the pregnancy? ☐ Yes ☐ No

Did the mother sustain any major injury/illness while pregnant? ☐ Yes ☐ No

Did the mother use tobacco, alcohol, street drugs or prescription drugs during pregnancy?

☐ Yes ☐ No

Was the delivery premature or overdue? ☐ Yes ☐ No

Were there complications with the labor/delivery? ☐ Yes ☐ No

**Development**

Gross motor development: ☐ Early ☐ Average ☐ Delayed ☐ Don't know

Fine motor development: ☐ Early ☐ Average ☐ Delayed ☐ Don't know

Cognitive development: ☐ Early ☐ Average ☐ Delayed ☐ Don't know

Expressive communication: ☐ Early ☐ Average ☐ Delayed ☐ Don't know

Receptive communication: ☐ Early ☐ Average ☐ Delayed ☐ Don't know

Self-care (feeding, dressing, toileting):

☐ Early ☐ Average ☐ Delayed ☐ Don't know

Social Skills: ☐ Early ☐ Average ☐ Delayed ☐ Don't know

Comments:

**Infant Temperament**

| | | | |
|---|---|---|---|
| Easy to comfort | ☐ Yes | ☐ No | ☐ Information not available |
| Quiet/aloof | ☐ Yes | ☐ No | ☐ Information not available |
| Excessive irritability | ☐ Yes | ☐ No | ☐ Information not available |
| Overactive | ☐ Yes | ☐ No | ☐ Information not available |

Describe early sleeping and feeding habits:

**Miscellaneous:**

Gang Involvement: ☐ Yes ☐ No Age: Grade: Select Grade

Immunizations current and up-to-date? ☐ Yes ☐ No

Any neuropsychological issues? ☐ Yes ☐ No

If yes, describe:

Has the client lived outside the home? ☐ Yes ☐ No

If yes, where?
- ☐ Foster Care
- ☐ Group Home
- ☐ Halfway House
- ☐ Hospital
- ☐ Relative
- ☐ Shelter
- ☐ Correctional Facility
- ☐ Other Residential Treatment Facility
- ☐ Residential Treatment Facility (Alcohol/Drug)

**Past Significant Events:**

- ☐ Significant medical condition of a parent/caregiver
- ☐ Medical conditional of a child
- ☐ Post-partum adjustment problems of mother
- ☐ Mental Illness of parent/caregiver
- ☐ Substance abuse of parent/caregiver
- ☐ Separation/ divorce of parent/caregiver

☐ Adoption

☐ Abandonment by significant adult caregiver

☐ Death of a parent/caregiver

☐ Mental retardation/developmental disorder of a parent/caregiver

☐ Incarceration of a parent/caregiver

**Completed by:**

Please type your full legal name: _____

Relationship to client: _____ Date: _____

**SCIOTO PAINT VALLEY MENTAL HEALTH CENTER**
**-SUBSTANCE ABUSE FORM-**

NAME: DATE: CLIENT ID:

PLEASE ANSWER THE QUESTIONS **ONLY** FOR SUBSTANCES YOU HAVE USED OR ARE USING.

| SUBSTANCE | USUAL ROUTE | HOW OLD WERE YOU WHEN YOU STARTED USING? | WHEN DID YOU LAST USE? | HOW MUCH/OFTEN WERE YOU USING? | HOW MUCH/OFTEN WAS THE MOST YOU'VE EVER DONE? |
|---|---|---|---|---|---|
| **ALCOHOL** | ORAL | | | | |
| **MARIJUANA** (THC, CANNIBIS) | SMOKE/ INHALE | | | | |
| **COCAINE** | ORAL/NOSE | | | | |
| **TRANQUILIZERS** (VALIUM, LIBRIUM) | | | | | |
| **AMPHETAMINES** (SPEED, UPPERS) | | | | | |
| **OPIATES** (HEROIN, DARVON, DILAUDID, PERCODAN, METHADONE, COCAINE, OXYCOTIN) | | | | | |
| **HALLUCINOGES** (ACID, MUSHROOMS) | | | | | |
| **INHALENTS** (PAINT, GLUE) | | | | | |
| **BARBITURATES** (BARBS, DOWNERS | | | | | |
| **OTHER SEDATIVES** (KUDES, 714'S) | | | | | |
| **PCP** (ANGEL DUST) | | | | | |
| **OVER-THE COUNTER** (NO-DOZE, DIET PILLS, COUGH SYRUP) | | | | | |
| **TOBACCO** (CIGARETTES, CHEW) | SMOKE/ INHALE | | | | |
| **SUBOXONE** (STREE PURCHASE, ILLEGAL) | | | | | |
| **SYNTHETIC CANNABINOIDS** (K2, SPICE, HERBAL INCENSE) | | | | | |

These questions refer to the past 12 months.

Circle your response

1. Have you used drugs other than those required for medical reasons? ..... Yes No
2. Have you abused prescription drugs? ..... Yes No
3. Do you abuse more than one drug at a time? ..... Yes No
4. Can you get through the week without using drugs? ..... Yes No
5. Are you always able to stop using drugs when you want to? ..... Yes No
6. Have you had "blackouts" or "flashbacks" as a result of drug use? ..... Yes No
7. Do you ever feel bad or guilty about your drug use? ..... Yes No
8. Does your spouse (or parents) ever complain about your involvement with drugs? ..... Yes No
9. Has drug abuse created problems between you and your spouse or your parents? ..... Yes No
10. Have you lost friends because of your use of drugs? ..... Yes No
11. Have you neglected your family because of your use of drugs? ..... Yes No
12. Have you been in trouble at work because of drug abuse? ..... Yes No
13. Have you lost a job because of drug abuse? ..... Yes No
14. Have you gotten into fights when under the influence of drugs? ..... Yes No
15. Have you engaged in illegal activities in order to obtain drugs? ..... Yes No
16. Have you been arrested for possession of illegal drugs? ..... Yes No
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? ..... Yes No
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)? ..... Yes No
19. Have you gone to anyone for help for a drug problem? ..... Yes No
20. Have you been involved in a treatment program specifically related to drug use? ..... Yes No

# Personal Drinking Questionnaire
# (SOCRATES)

INSTRUCTIONS: Please read the following statements carefully. Each one describes a way that you might (or might not) feel *about your drinking*. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it *right now*. Please circle one and only one number for every statement.

| | NO! Strongly Disagree | No Disagree | ? Undecided or Unsure | Yes Agree | YES! Strongly Agree |
|---|---|---|---|---|---|
| 1. I really want to make changes in my drinking. | 1 | 2 | 3 | 4 | 5 |
| 2. Sometimes I wonder if I am an alcoholic. | 1 | 2 | 3 | 4 | 5 |
| 3. If I don't change my drinking soon, my problems are going to get worse. | 1 | 2 | 3 | 4 | 5 |
| 4. I have already started making some changes in my drinking. | 1 | 2 | 3 | 4 | 5 |
| 5. I was drinking too much at one time, but I've managed to change my drinking. | 1 | 2 | 3 | 4 | 5 |
| 6. Sometimes I wonder if my drinking is hurting other people. | 1 | 2 | 3 | 4 | 5 |
| 7. I am a problem drinker. | 1 | 2 | 3 | 4 | 5 |
| 8. I'm not just thinking about changing my drinking, I'm already doing something about it. | 1 | 2 | 3 | 4 | 5 |
| 9. I have already changed my drinking, and I am looking for ways to keep from slipping back to my old pattern. | 1 | 2 | 3 | 4 | 5 |
| 10. I have serious problems with drinking. | 1 | 2 | 3 | 4 | 5 |
| 11. Sometimes I wonder if I am in control of my drinking. | 1 | 2 | 3 | 4 | 5 |
| 12. My drinking is causing a lot of harm. | 1 | 2 | 3 | 4 | 5 |
| 13. I am actively doing things now to cut down or stop drinking. | 1 | 2 | 3 | 4 | 5 |
| 14. I want help to keep from going back to the drinking problems that I had before. | 1 | 2 | 3 | 4 | 5 |
| 15. I know that I have a drinking problem. | 1 | 2 | 3 | 4 | 5 |
| 16. There are times when I wonder if I drink too much. | 1 | 2 | 3 | 4 | 5 |
| 17. I am an alcoholic. | 1 | 2 | 3 | 4 | 5 |
| 18. I am working hard to change my drinking. | 1 | 2 | 3 | 4 | 5 |
| 19. I have made some changes in my drinking, and I want some help to keep from going back to the way I used to drink. | 1 | 2 | 3 | 4 | 5 |

# Personal Drug Use Questionnaire
# (SOCRATES)

INSTRUCTIONS: Please read the following statements carefully. Each one describes a way that you might (or might not) feel *about your drug use*. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it *right now*. Please circle one and only one number for every statement.

| | NO! Strongly Disagree | No Disagree | ? Undecided or Unsure | Yes Agree | YES! Strongly Agree |
|---|---|---|---|---|---|
| 1. I really want to make changes in my use of drugs. | 1 | 2 | 3 | 4 | 5 |
| 2. Sometimes I wonder if I am an addict. | 1 | 2 | 3 | 4 | 5 |
| 3. If I don't change my drug use soon, my problems are going to get worse. | 1 | 2 | 3 | 4 | 5 |
| 4. I have already started making some changes in my use of drugs. | 1 | 2 | 3 | 4 | 5 |
| 5. I was using drugs too much at one time, but I've managed to change that. | 1 | 2 | 3 | 4 | 5 |
| 6. Sometimes I wonder if my drug use is hurting other people. | 1 | 2 | 3 | 4 | 5 |
| 7. I have a drug problem. | 1 | 2 | 3 | 4 | 5 |
| 8. I'm not just thinking about changing my drug use, I'm already doing something about it. | 1 | 2 | 3 | 4 | 5 |
| 9. I have already changed my drug use, and I am looking for ways to keep from slipping back to my old pattern. | 1 | 2 | 3 | 4 | 5 |
| 10. I have serious problems with drugs. | 1 | 2 | 3 | 4 | 5 |
| 11. Sometimes I wonder if I am in control of my drug use. | 1 | 2 | 3 | 4 | 5 |
| 12. My drug use is causing a lot of harm. | 1 | 2 | 3 | 4 | 5 |
| 13. I am actively doing things now to cut down or stop my use of drugs | 1 | 2 | 3 | 4 | 5 |
| 14. I want help to keep from going back to the drug problems that I had before. | 1 | 2 | 3 | 4 | 5 |
| 15. I know that I have a drug problem. | 1 | 2 | 3 | 4 | 5 |
| 16. There are times when I wonder if I use drugs too much. | 1 | 2 | 3 | 4 | 5 |
| 17. I am a drug addict. | 1 | 2 | 3 | 4 | 5 |
| 18. I am working hard to change my drug use. | 1 | 2 | 3 | 4 | 5 |
| 19. I have made some changes in my drug use, and I want some help to keep from going back to the way I used before | 1 | 2 | 3 | 4 | 5 |