The Steven A. Cohen Military Family Clinic at Easterseals

OFFICE USE ONLY: V42021

Date of Initial Appointment: _____

ID#: _____

Staff Member:: _____

## Personal Information

Full Name: _____
*Last* *First* *M.I.*

Address: _____
*Street Address* *Apartment/Unit #*

_____
*City* *State* *Zip Code*

_____
*County*

Date of Birth: _____ Age: _____ Are you a registered sex offender? Yes __ No __

Gender (please circle): Male Female Transgender (Preferred pronoun) _____

Other/Non-conforming (Preferred pronoun) _____ Social Security Number: _____

| | | Mobile provider? | Ok to leave a Message? | Text Message? |
|---|---|---|---|---|
| Mobile Phone: | _____ | _____ | Yes __ No __ | Yes __ No __ |
| Day Phone: | _____ | _____ | Yes __ No __ | Yes __ No __ |
| Evening Phone: | _____ | _____ | Yes __ No __ | Yes __ No __ |

Email Address: _____
Okay to send email? Yes ___ No ____ *Please note, for your privacy minimal information will be sent electronically. (Example, no names - just dates, times and logistical information)*

Preferred method of contact? ☐ Phone Call ☐ Email ☐ Other:_____

Preferred Language _____ Secondary Language _____

Do you currently have health insurance? Yes __ No __ If yes, what type of health insurance? _____

If Tricare Insurance, please provide your Benefits ID Number: _____

If Commercial Insurance, please provide your Member ID _____ and Group # _____

Race/Ethnicity: *(Circle all that apply)*

| | | | |
|---|---|---|---|
| American Indian/ Alaska Native | Asian/ South Asian | Black/ African American | Hispanic/ Latino |
| Native Hawaiian/ Pacific Islander | White/ Caucasian | Other: _____ | |

Any barriers to care or special accommodations needed (language, physical, cultural, spiritual or otherwise)?

_____

_____

How did you hear about us? Please explain (who, where, when, etc) _____

_____

## Emergency Contact Information

Full Name: _____
*Last* *First* *M.I.*

Address: _____
*Street Address* *Apartment/Unit #*

_____
*City* *State* *Zip Code*

_____
*County*

Relationship to Client: _____ Gender: _____

| | | Mobile phone? | Mobile Provider? | Ok to leave a Message? |
|---|---|---|---|---|
| Mobile Phone: | _____ | Yes __ No __ | _____ | Yes ___ No __ |
| Alternate Phone: | _____ | Yes __ No __ | _____ | Yes __ No ___ |

## Military Background

Did you serve in the United States military? Yes __ No __ Military Branch: _____

***If you did not serve in the military, please skip to the Military Background - Family Member Section.***

Are you/were you in the National Guard? Yes___ No ___ Are you/were you in the Reserves? Yes__ No ___

If Guard or Reserve, circle one: Currently in but not active on Active orders Retired / Separated

Military rank: _____ Occupational Specialty: _____

Are you a post 9/11 Veteran (served on or after 9/11/2001)? Yes __ No __

Are you currently Active Duty? Yes __ No __ Did you receive a DD 214 Yes __ No __

Military discharge status (please Circle): Honorable General Other than honorable N/A

Are you enrolled in VA Health care? Yes __ No __ if yes, where? _____

Do you receive any of the following VA benefits? (Please circle all that apply)

Primary Health Care Mental Health Evaluation Mental Health Treatment

Prescription Medications HUD/VASH Specialty Care

Other _____

Did you receive a disability rating through the VA? Yes__ No __ if yes, what is your percentage? _____

Are you a Military Caregiver (a military caregiver is a family member, friend or acquaintance who provides a broad range of care and assistance for, or manages the care of, a current or former military service member with a disabling physical or mental injury or illness regardless of official designation) Yes __ No __

## Military Background – Family Member

***Complete if using a Military Family member to receive services at our clinic.***
***Not all Military Family members need to be identified, although their service is appreciated.***

If you did not serve in the military, did a family member serve? Yes __ No __ Which Branch?_____

Which family member? (Only one needed) _____

Is your family member a post 9/11 Veteran (served on or after 9/11/2001)? Yes __ No __

Military status (please circle): Active Duty Guard / Reserve Honorable discharge

General discharge Other than honorable discharge Other: _____ Unknown

Enrolled in VA Health care? Yes __ No__ Unknown __

Did they receive a VA disability rating? Yes__ No __ Unknown ___ If yes, what percentage? _____

Are you a caregiver for your veteran family member? Yes___ No___

Are you a Military Caregiver to anyone? (a military caregiver is a family member, friend or acquaintance who provides a broad range of care and assistance for, or manages the care of, a current or former military service member with a disabling physical or mental injury or illness regardless of official designation) Yes __ No __

## Personal Background Information

Marital Status: *(Circle all that apply)*

Now Married  Divorced  Separated  Widowed

Never Married  Living with partner  Other: _____

Highest level of education completed: *(Circle one)*

Less than high school  High school/GED  Associates degree  College degree

Post college degree  Other: _____

Current employment status: *(Circle one)*

Full-time  Part-time  Unemployed  Do not work

Other: _____

Employer? _____

What is your annual household income? $_____

How much of your annual household income comes from wages? $_____

How much of your annual household income comes from subsidies
(e.g., disability benefits/social security/TANF/other support)? $_____

Please select which subsidies: VA Disability Benefits TANF SSDI Other:_____

Who currently resides in your home?

| Name | Age & Gender | Relationship to Client |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Are there any firearms in your home? Yes __ No __

If yes, please provide more information (if they are locked, who has access, etc): _____

_____

## Medical History

Name of Primary Care
Physician and clinic. :_____

_____

Date of last physical exam: _____

Name of other Medical providers and specialty. (Chiropractic, Rheumatology, etc) : _____

_____

_____

_____

Do you have any chronic illnesses or current physical problems? Yes __ No __

Do you smoke? Yes __ No __

Do you have any Medication Allergies? Yes ___ No __ If yes, what? _____

Are you taking any prescription or non-prescription medications? Yes __ No __

Are you currently Pregnant or taking prenatal care? Yes___ No __ N/A ___

What are your current medications? (Please provide medication name, dose and frequency)

_____

_____

_____

_____

_____

_____

Do you feel your medications are effective? Yes___ No __ N/A ___

If **NO** please explain, _____

Are you concerned about any side effect or adverse reaction? Yes___ No __ N/A ___

If **YES**, please explain? _____

**In the past 2 weeks**, were there any changes in medication? Yes __ No __

If YES, what were the changes? _____

Do you drink Alcohol? Yes __ No__

If yes, how much do you drink? _____ How often? _____

Do you use any recreational drugs? Yes ___ No____ What do you use? _____

If yes, how much do you use? _____ How often? _____

In the past 3 months, have you been experiencing pain that interferes with your normal Activities on **more than half the days each month?** Yes __ No __

If yes, please rate your pain by circling the number that best describes your pain in the last 24 hours:

1 No pain 2 3 4 5 6 7 8 9 10 As bad as you can imagine

How much has your pain interfered with your normal activities (including work outside and inside the house)?

1 No Interference 2 3 4 5 6 7 8 9 10 Complete interference

Do you need additional help with your pain? Yes __ No __

## Mental Health History

Have you ever received counseling, psychological, or psychiatric treatment? Yes __ No __

Are you currently receiving counseling, psychological, or psychiatric treatment? Yes __ No __

Please list below all current or past mental health care you have received starting with your most recent.

| Type of treatment (Counseling, inpatient, Medication only, etc) | Type of problem | approx. Dates/years | Where did you receive treatment? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

If currently in mental health treatment, would you be okay with us contacting your current mental health provider(s) for continuity of care?

Yes __ No __ (note that a release of information is required before we will contact.)

Were you satisfied with any mental health treatment you have received? Yes __ No __

Is there any family history of mental health concerns (e.g. depression?) Yes __ No __

If yes, please explain: _____