The Steven A. Cohen Military Family Clinic at Easterseals

OFFICE USE ONLY: V3 2019

Date of appt: ____________________

ID#: ____________________

Staff mbr: ____________________

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 select)*

	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 __ Social Security Number:____________________

If yes, what type of health insurance? ____________________

If Tricare Insurance, please provide DOD Benefits ID Number: ____________________

Race/Ethnicity: *(please select)* 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, select one:

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 select)*

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

Do you receive any of the following VA benefits? *(Please select 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 __ Unsure __

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: *(Select all that apply)*

Now Married   Divorced   Separated   Widowed

Never Married   Living with partner   Other: __________________________

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

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

Post college degree   Other: _______________________________

Current employment status: *(Select 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: ____