Date: _____

Center for Family Development (CFD)
MH Program Data Packet

*****Please complete these pages for the person who is receiving services*****

Legal Name: _____ Last Name at Birth: _____

Preferred Name: _____ Date of Birth: _____

Name of person completing form (if other than client): _____

Name and relationship of referral source: ☐ Self ☐ Other: _____

Physical Address: _____ City, State, Zip: _____

Mailing Address (if different): _____ City, State, Zip: _____

Contact Phone Numbers		Phone type	Number belongs to:	Ok to leave a message?	Ok to identify we are calling from CFD?
Primary #		☐ Cell ☐ Home ☐ Work ☐ Message		☐ Yes ☐ No	☐ Yes ☐ No
Alternate #		☐ Cell ☐ Home ☐ Work ☐ Message		☐ Yes ☐ No	☐ Yes ☐ No
How would you like to receive appointment confirmations?		☐ Call ☐ Text	**Send confirmations to:**	☐ Primary Number ☐ Alternate Number	

* By marking yes to receive appointment confirmations by text in the box above, I request that confirmation of my appointments be done by text message. I understand I will not receive confirmation by telephone calls. If my text message number changes, I will notify CFD. I am aware that information contained in text messages cannot always be guaranteed to remain confidential due to the limitations of electronic media. ***** Text confirmation is only available for clients seen at the CFD downtown locations *****

Gender as Specified on Insurance: ☐ Male ☐ Female Gender Self-Identification, if different: ☐ Male ☐ Female ☐ Other

Preferred pronouns: ☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Ze/hir ☐ Other: _____

Race:

☐ Alaskan Native
☐ American Indian
☐ Black or African American
☐ White
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Other Single Race
☐ Two or More Unspecified Races
☐ Decline to answer
☐ Unknown

Ethnicity:

☐ Mexican
☐ Not of Hispanic Origin
☐ Unknown
☐ Puerto Rican
☐ Hispanic- Specific Origin not Specified
☐ Decline to answer
☐ Other Specific Hispanic
☐ Cuban

Living Status

☐ Private Residence (at home)
☐ Private Residence (with relative)
☐ Private Residence (with non-relative)
☐ Private Residence (other)
☐ Transient/Homeless
☐ Foster Home
☐ Room and Board
☐ Supported Housing
☐ Alcohol and Drug Free Housing
☐ Residential Facility (for alcohol/drugs/SUDs)
☐ Residential Facility for (for mental health/BRS)

Tribal Member: ☐ Yes ☐ No Tribe name: _____

Marital Status: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Tobacco Use: ☐ Yes ☐ No If yes, which type?: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing Tobacco

Smoking Status:

☐ Former Smoker
☐ Never Smoked
☐ Heavy Tobacco User
☐ Light Tobacco User
☐ Current Some Day Smoker
☐ Current Every Day Smoker
☐ Smoker, Current Status Unknown
☐ Unknown If Ever Smoked

Language

Preferred language: _____ Is a translator needed?: ☐ Yes ☐ No

Military Status: Are you currently serving in the military?

☐ Yes
☐ Yes, veteran and current/former active duty
☐ No, but current or former guard/reserves
☐ Yes, veteran and current/former guard/reserves
☐ No

Legal Issues:

☐ None
☐ Unknown
☐ DUII Diversion Client
☐ DUII Convicted Client
☐ Probation
☐ Psychiatric Security Review Board
☐ 30-Day Civil Commitment
☐ 90-Day Civil Commitment
☐ 180-Day Civil Commitment
☐ Parole
☐ Pre-Arrest Jail Diversion (non-DUII)
☐ Aid and Assist (ORS 161.370)
☐ Juvenile Psychiatric Security Review Board
☐ Guardianship (Court)
☐ Guardianship (Child Welfare)
☐ Post-Arrest Jail Diversion (non-DUII)

Arrest History:

Number of Arrests in Past Month: _____ Total Arrests: _____

Number of DUII Arrests in Past Month: _____ Total DUII Arrests: _____

Substance Use in Last 90 Days: ☐ Yes ☐ No

Employment Status:

☐ Full time
☐ Part time
☐ Unemployed
☐ Homemaker
☐ Student
☐ Retired
☐ Disabled (unable to work for physical or psychological reasons)
☐ Other (volunteer, intern, etc.)

Education: Highest grade completed: _____

Household Income:

Estimated gross household ***yearly*** income**:** $_____

Number of people supported by household income (include self): _____

Number of child dependents (Ages 0-17 supported by household income): _____

Principle Income Source:

☐ Wages, salary
☐ Public assistance
☐ Retirement/Pension/SSI
☐ Disability/SSDI
☐ None
☐ Other

Emergency Contact Information:

Name: _____ Relationship: _____

Address: _____ Phone number: _____

Medical Information:

Primary Care Physician's Name (PCP): _____

Phone: _____ Fax: _____

When was the last time you saw your PCP?: _____

Dentist's Name: _____

Phone: _____ Fax: _____

Psychiatrist/Psychiatric Nurse Practitioner Name: _____

Phone: _____ Fax: _____

Name: _____

Describe any birth and early childhood complications, medical problems, or developmental delays: _____

_____

_____

In the last year have you utilized other social service agencies (e.g. DHS Child Welfare, Self Sufficiency, Social Security)?

☐ Yes ☐ No If yes, where: _____

In the last year have you accessed other behavioral health provider agencies like Center for Family Development? ☐ Yes ☐ No

If yes, where: _____

Please list *current* drug/alcohol and/or gambling services: _____

_____

Please list previous mental health, drug/alcohol and/or gambling services: _____

_____

Please list any problems you are having at this time:

1. _____
2. _____
3. _____
4. _____

Women Only:

Are you pregnant? ☐ Yes ☐ No If pregnant, are you receiving prenatal care? ☐ Yes ☐ No

If yes, who is your prenatal healthcare provider? _____

Phone: _____ Fax: _____

This page is for YOUTH only. Parent or Guardian: Please complete this form

Name of Youth: _____ Date of Birth: _____

Biological mother: _____ Step-mother: _____

Biological father: _____ Step-father: _____

Adoptive/foster parents: _____

Name of adult(s) legally authorized (legal guardian) to consent for services: _____

Is there a legal parenting plan or custody agreement in place? ☐ Yes ☐ No

If yes, please note: CFD requires a copy of the legal documentation of parenting or custody agreement in order to provide services. The legal guardian must be present to consent to services.

Is custody being contested? ☐ Yes ☐ No

If yes, please describe: _____

_____

Describe any conflict in family relationships that impact the child: _____

_____

Significant others involved in the child's life: _____

_____

If your child has ever been sexually, physically, or emotionally/verbally abused, please describe: _____

_____

Has your child ever: ☐ Been cruel to animals ☐ Set fires

Has your child ever witnessed domestic violence? ☐ Yes ☐ No

Has your child ever experienced the loss or death of a significant family member? ☐ Yes ☐ No

Does your child have difficulty making or keeping friends? ☐ Yes ☐ No

Does your child currently express thoughts of harming him/herself or others? _____

If so, how likely is your child to act on these thoughts? ☐ Unlikely ☐ Likely

Has he/she had thoughts of harming him/herself or others in the past? _____

Has your child or anyone in your family ever received counseling? ☐ Yes ☐ No

Has anyone in the family threatened or attempted suicide? ☐ Yes ☐ No

Has a family member's drug or alcohol use caused problems in the family? ☐ Yes ☐ No

Has your child, or any family member, had legal problems? ☐ Yes ☐ No

Grades received: In school, the child has:

☐ High	☐ No behavioral problems	☐ Learning disability
☐ Average	☐ Some behavioral problems	☐ Individualized Education
☐ Low	☐ Frequent behavioral problems	Plan (IEP)

Date: _____ **Name**: _____

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	Over half the days	Nearly every day
Feeling down, depressed, irritable, or hopeless?	0	1	2	3
Little interest or pleasure in doing things?	0	1	2	3
Trouble falling asleep, staying asleep, or sleeping too much?	0	1	2	3
Poor appetite, weight loss, or overeating?	0	1	2	3
Feeling tired, or having little energy?	0	1	2	3
Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	0	1	2	3
Trouble concentrating on things like school work, reading, or watching TV?	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way?	0	1	2	3
In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes? ☐ Yes ☐ No				
If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people? ☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult				
Has there been a time in the **past month** when you have had serious thoughts about ending your life? ☐ Yes ☐ No				
Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No				
TOTAL SCORE				

If you checked off any problems from this list, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3
Add Columns				
TOTAL SCORE				

If you checked off any problems from this list, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult