Date: _____

Center for Family Development (CFD)
Recovery 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): _____

How were you referred to CFD? ☐ Self ☐ Other- Name of person who referred: _____ Relationship to client: _____

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 contact information 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
☐ 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 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: _____

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: _____

DUII Clients Only:

Oregon Driver's License or I.D.# if no license: _____

Some people experience things that make life more difficult. Please check those the things listed below that you are concerned about:

☐ My job	☐ Having enough money	☐ Having enough food
☐ My family	☐ Feeling lonely	☐ Feeling angry
☐ My health	☐ My children	☐ My home
☐ My medications	☐ Feeling sad	☐ Feeling overwhelmed
☐ Difficult memories	☐ My sadness and grief	☐ Feeling scared

Please list current mental health, drug/alcohol and/or gambling services you are receiving: _____

_____

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

Infectious Disease Risk Assessment

The following questions are necessary to assess your risk for infectious diseases. Please answer these questions. Confidentiality laws protect all answers.

Name: _____ **Date of Birth:** _____ **Date:** _____

Infectious Disease Risk	Yes	No	Don't Know
Have you seen a health care provider in the past three months?			
Do you or have you lived on the street or in a shelter?			
Have you ever been in jail/prison/juvenile detention?			
Have you ever been in a long-term care facility (mental health hosp, nursing home, rehab)?			
In the past 3 months, have you traveled outside the US? (where:_____)			
Are you a combat veteran?			
In the past year, have you had a tattoo, body piercing, acupuncture, or contact with blood?			
Where were you born?			
How long have you been in the US?			
Have you lived with anyone diagnosed with TB in the past year?			
Have you ever been treated for TB?			
Have you ever been told you have Hepatitis A?			
Have you ever been told you have Hepatitis B?			
Have you ever been told you have Hepatitis C?			
Have you ever used needles to shoot drugs?			
Have you ever shared needles or syringes to inject drugs?			
Have you ever had a job where you were at risk for needle sticks or blood contact?			
In the past year, have you or anyone you had sex with had an STD or Hepatitis?			
In the past 30 days have you had any of these symptoms lasting more than 2 weeks:			
Nausea			
Fever			
Drenching night sweats that were so bad you had to change clothes or bed sheets			
Productive cough			
Coughing up blood			
Shortness of breath			
Lumps or swollen glands in the neck or armpits			
Loss of weight without trying to			
Diarrhea lasting more than a week			
Brown tinged urine			
Extreme fatigue			
Jaundice or yellow eyes			
Women: Missed periods for last two months			

HIV/AIDS/Hepatitis C Risk	Yes	No	Don't Know
Did you receive a blood transfusion before 1992?			
Have you received blood products produced before 1987 for clotting problems?			
Was your birth mother infected by Hepatitis C during the time of your birth?			
Have you been or are you currently on long-term kidney dialysis?			
Have you had unprotected sex with someone who has the blood disease hemophilia?			
Have you had unprotected sex with a person who injects drugs?			
Have you had unprotected sex with a man who has sex with other men?			
Have you had sex in exchange for money or drugs in order to survive?			
Have you had unprotected sex with more than one partner in the past 6 months?			
Have you had sex or shared needles with a person who has AIDS, HIV+, or Hep C +?			
Have you ever injected drugs, even once?			
Have you ever been pricked by a needle that may have been infected with HIV or Hep C?			
Have you ever had a test for HIV?			
If yes, was it within the last six months?			
If no, would you like to be tested?			
Have you ever had a blood test for Hepatitis C?			
If yes, was it within the last six months?			
If no, would you like to be tested?			

How would you judge your own risk for being infected with HIV? (Please check one):

☐ I know I am infected ☐ I think I am at high risk ☐ I think I am at low risk ☐ I choose to not disclose my status

☐ I think I am at **NO** risk ☐ I am not sure what my risk is

How would you judge your own risk for being infected with Hepatitis C? (Please check one):

☐ I know I am infected ☐ I think I am at high risk ☐ I think I am at low risk

☐ I think I am at **NO** risk ☐ I am not sure what my risk is

Signature Date