

Center for Family Development (CFD)

Recovery Program Data Packet

Date: _____

****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 #		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Message		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alternate #		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Message		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
How would you like to receive appointment confirmations?		<input type="checkbox"/> Call <input type="checkbox"/> Text	Send confirmations to:	<input type="checkbox"/> Primary Number <input type="checkbox"/> 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:

- | | | |
|--|--|--|
| <input type="checkbox"/> Alaskan Native | <input type="checkbox"/> Asian | <input type="checkbox"/> Two or More Unspecified Races |
| <input type="checkbox"/> American Indian | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | <input type="checkbox"/> Decline to answer |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Other Single Race | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> White | | |

Ethnicity:

- | | | |
|---|--|--|
| <input type="checkbox"/> Mexican | <input type="checkbox"/> Puerto Rican | <input type="checkbox"/> Other Specific Hispanic |
| <input type="checkbox"/> Not of Hispanic Origin | <input type="checkbox"/> Hispanic- Specific Origin not Specified | <input type="checkbox"/> Cuban |
| | <input type="checkbox"/> Decline to answer | |

Living Status

- | | | |
|--|--|---|
| <input type="checkbox"/> Private Residence (at home) | <input type="checkbox"/> Foster Home | <input type="checkbox"/> Residential Facility (for alcohol/drugs/SUDs) |
| <input type="checkbox"/> Private Residence (with relative) | <input type="checkbox"/> Room and Board | <input type="checkbox"/> Residential Facility (for mental health / BRS) |
| <input type="checkbox"/> Private Residence (with non-relative) | <input type="checkbox"/> Supported Housing | |
| <input type="checkbox"/> Private Residence (other) | <input type="checkbox"/> Alcohol and Drug Free Housing | |
| <input type="checkbox"/> Transient/Homeless | | |

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:

- | | | |
|---|---|--|
| <input type="checkbox"/> My job | <input type="checkbox"/> Having enough money | <input type="checkbox"/> Having enough food |
| <input type="checkbox"/> My family | <input type="checkbox"/> Feeling lonely | <input type="checkbox"/> Feeling angry |
| <input type="checkbox"/> My health | <input type="checkbox"/> My children | <input type="checkbox"/> My home |
| <input type="checkbox"/> My medications | <input type="checkbox"/> Feeling sad | <input type="checkbox"/> Feeling overwhelmed |
| <input type="checkbox"/> Difficult memories | <input type="checkbox"/> My sadness and grief | <input type="checkbox"/> Feeling scared |

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

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
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself, or that you are a failure or have let yourself or your family down.	0	1	2	3
Trouble concentrating on things such as reading or watching television	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 have been moving around a lot more than usual.	0	1	2	3
Thoughts of that you would be better off dead, or of hurting yourself in some way	0	1	2	3
If so, how likely are you to act on these thoughts? <input type="checkbox"/> Unlikely <input type="checkbox"/> Likely				
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

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):			
<input type="checkbox"/> I know I am infected <input type="checkbox"/> I think I am at high risk <input type="checkbox"/> I think I am at low risk <input type="checkbox"/> I choose to not disclose my status <input type="checkbox"/> I think I am at NO risk <input type="checkbox"/> I am not sure what my risk is			
How would you judge your own risk for being infected with Hepatitis C? (Please check one):			
<input type="checkbox"/> I know I am infected <input type="checkbox"/> I think I am at high risk <input type="checkbox"/> I think I am at low risk <input type="checkbox"/> I think I am at NO risk <input type="checkbox"/> I am not sure what my risk is			

Signature

Date