TODAY'S DATE: _____ Chart # _____

Request for Services

APPLICANT NAME: _____ GENDER: FEMALE MALE
LAST, FIRST, MIDDLE NAME (MAIDEN, IF APPLICABLE)

ADDRESS / CITY / STATE / ZIP: _____

DATE OF BIRTH: _____AGE: _____ PHONE: _____ Soc. Sec. #: _____

ALTERNATE PHONE NUMBER: _____ HOW DO YOU PREFER WE GET IN TOUCH WITH YOU? _____
(INCLUDE EMAIL HERE, IF APPLICABLE): _____
_____

EMERGENCY CONTACT NAME, ADDRESS, AND PHONE NUMBER:_____
_____
DO YOU LIVE WITH YOUR EMERGENCY CONTACT? □NO □YES
EMERGENCY CONTACT'S RELATIONSHIP TO CLIENT: _____
SOURCE / PROVIDER OF INFORMATION: _____
DO YOU HAVE A LEGAL GUARDIAN / CUSTODIAN? IF SO, PLEASE INCLUDE NAME AND PHONE NUMBER:

ARE YOU CURRENTLY, OR HAVE YOU EVER, RECEIVED SERVICES FOR A MENTAL HEALTH OR SUBSTANCE USE CONCERN? NO YES

IF YES, WHERE AND APPROXIMATELY WHEN? UNDER WHAT NAME? _____
_____

WHEN WAS YOUR LAST TB TEST?_____ ARE YOU HIV+? □NO □YES □PREFER NOT TO ANSWER

HAVE YOU EVER HAD A TB SKIN TEST COME BACK POSITIVE? □NO □YES IF YES, WHEN?_____

HAVE YOU WORKED IN HEALTH CARE, OR STAYED IN A HOMELESS SHELTER, JAIL, OR PRISON FOR MORE THAN 8 HOURS AT A TIME IN THE PAST YEAR? □NO □YES

HAVE YOU LIVED WITH OR SPENT MORE THAN 8 HOURS AT A TIME WITH SOMEONE WHO YOU KNEW WAS SICK FROM TB?
□NO □YES

WHERE WERE YOU BORN?_____

HOW CAN WE HELP YOU TODAY? WHAT ARE YOUR IMMEDIATE NEEDS RELATED TO MENTAL HEALTH AND/OR SUBSTANCE USE CONCERNS:_____

_____

_____

Are you interested in a specific program? If yes, please name the program:

_____

ARE YOU CURRENTLY HAVING THOUGHTS OF HARMING YOURSELF OR ANYONE ELSE?	NO	YES
DO YOU HAVE ANY CONCERNS FOR YOUR SAFETY?	NO	YES
ARE YOU SEEKING RESIDENTIAL TREATMENT SERVICES FOR SUBSTANCE ABUSE?	NO	YES

ANNUAL HOUSEHOLD INCOME: _____ # IN HOUSEHOLD? _____

SOURCE(S) OF INCOME: (CHECK ALL THAT APPLY) EMPLOYMENT SSI SSDI FOOD STAMPS TANF

OTHER: _____

DO YOU HAVE HEALTH INSURANCE? NO YES - IF YES, WITH WHOM AND INCLUDE YOUR ID NUMBER: _____

_____

RACE (CHECK ONLY ONE): AMERICAN INDIAN BLACK / AFRICAN AMERICAN ASIAN WHITE
NATIVE HAWAIIAN/PACIFIC ISLANDER

☐ HISPANIC ☐ NOT HISPANIC PREFERRED LANGUAGE: ENGLISH OTHER _____

OTHER LANGUAGES SPOKEN: _____

WHO REFERRED YOU HERE TODAY? MYSELF OTHER: _____

IF REFERRED BY THE COURT / CRIMINAL JUSTICE SYSTEM, IN WHAT COUNTY WERE THE LEGAL PROCEEDINGS HELD? _____

_____

ARE YOU CURRENTLY HOMELESS? NO YES IF YES, HOW LONG HAVE YOU BEEN HOMELESS? _____

HAVE YOU BEEN HOMELESS AT ANY TIME DURING THE PAST THREE (3) YEARS? NO YES IF YES, HOW MANY TIMES? _____

DO YOU NEED ANY SPECIAL HELP OR EQUIPMENT TO ACCESS SERVICES? NO YES -IF YES, WHAT? _____

MARITAL STATUS OF PERSON REQUESTING SERVICES: ☐ NEVER MARRIED ☐ MARRIED ☐ DIVORCED ☐ SEPARATED
☐ WIDOWED ☐ LIVING AS MARRIED

DO YOU USE TOBACCO PRODUCTS (INCLUDING E-CIGARETTES, VAPING)? IF YES, HOW MANY TIMES PER DAY? _____

MILITARY STATUS OF CLIENT: ☐ NONE ☐ CURRENTLY ACTIVE ☐ PREVIOUSLY ACTIVE ☐ NATIONAL GUARD/RESERVE
MILITARY STATUS OF FAMILY MEMBER ☐ NONE ☐ CURRENTLY ACTIVE ☐ PREVIOUSLY ACTIVE ☐ NATIONAL GUARD/RESERVE

I CONSENT TO RECEIVE TREATMENT AT RED ROCK BEHAVIORAL HEALTH SERVICES (RR). I AUTHORIZE RR TO USE/DISCLOSE MY HEALTH INFORMATIN TO OBTAIN PAYMENT FOR THE SERVICES RECEIVED. I UNDERSTAND A BILL MAY BE SENT TO ME AND/OR A THIRD PARTY PAYOR. I ASSIGN ALL INSURANCE BENEFITS TO WHICH I AM ENTITLED TO RR. THIS AGREEMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING OR WHEN ALL THIRD PARTY CLAIMS ARE SATISFIED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ, OR HAD THIS INFORMATION READ TO ME, AND UNDERSTAND IT.

_____ _____
SIGNATURE DATE

_____ _____
SIGNATURE OF GUARDIAN, IF IN GUARDIANSHIP DATE

CLIENT NAME:_____ CHART #_____

PATIENT HEALTH QUESTIONNAIRE – 9
(PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle the appropriate response)	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you circled <u>any</u> problems above, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or take care of other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

<u>RED ROCK STAFF Signature and Date:</u> _____

<u>The above RED ROCK STAFF MEMBER entered the scores on this form into AVATAR and the form was scanned into client chart and labeled RFS/PHQ9.</u> _____

CLIENT NAME:_____ CHART #_____