LUTHERAN Community Services NORTHWEST

Health. Justice. Hope.

Office Use Only:
Date and Time of First Contact _____
Date and Time of Intervention _____

Personal Information Form

PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS *(This information is confidential and will not be shared outside of this agency)*

IMPORTANT PLEASE COMPLETE: Check all that apply

Routine:	**Urgent:**	**Crisis:**
☐ Are you here to establish mental health care? ☐ Are you here to establish substance use care? ☐ Other: _____	☐ Do you feel that you cannot keep yourself safe longer than 48 hours? ☐ Are you pregnant? ☐ Are you an IV Drug User?	☐ Do you feel you are currently a danger to yourself? ☐ Do you feel you are currently a danger to others?

Today's Date: _____ **Preferred Pronouns:** he/him/his she/her/hers they/them/theirs

Legal Full Name: _____ FIRST MI LAST _____

Last Name at Birth: _____ **Preferred name:** _____ **SSN:** _____ - _____ - _____

Physical Address: _____

Mailing Address (if different than above): _____

Preferred method of contact? *(check all that apply)* ☐ Phone ☐ Text Messaging ☐ E-mail

Primary Phone: (_____) _____ **Secondary Phone**: (_____) _____

Email Address: _____

Is it OK to call these numbers and leave a voicemail? ☐ Yes ☐ No

What can we contact you about? *(check all that apply)* ☐ Appointments ☐ Healthcare Information

Living Arrangement: ☐ Homeless ☐ Private Residence ☐ Other _____

Date of Birth: _____ **Age**: _____ **Sex:** ☐ Male ☐ Female ☐ Other: _____

Race/Ethnicity:

☐ Native American/Alaska Native ☐ Asian
☐ Black/African American ☐ Caucasian
☐ Native Hawaiian/Other Pacific Islander
☐ Hispanic/Latino ☐ Other Race

Marital Status:

☐ Never Married ☐ Widowed
☐ Married ☐ Separated
☐ Divorced ☐ Domestic Partner

Military Status:

☐ Veteran & Current/Former Active Duty Military
☐ Veteran & Current/Former Guard/Reserve
☐ Not a Veteran but Current/Former Guard/Reserve
☐ Not a Veteran

Employment Status:

☐ Full Time ☐ Part Time (17-34 hours)
☐ Student ☐ Retired
☐ Disabled ☐ Unemployed
☐ Homemaker ☐ Irregular Work

FOR PRINEVILLE CLIENT'S ONLY
If you are unemployed are you interested in employment? ☐ Yes ☐ No
Would you like to receive more information on Supported Employment? ☐ Yes ☐ No

What has caused you to seek services at this time (Alcohol/Drug concerns? Mental Health issues)? _____

_____ .

Were you born in the U.S.? ☐ **Yes** ☐ **No** **If not, which country were you born in?** _____

Primary Language: _____ **Religious Preference:** _____

Estimated Gross Household Monthly Income (Includes TANF): $_____

Source of Income: ☐ Wages ☐ Public Assistance ☐ Disability ☐ Retirement ☐ Pension ☐ SSI ☐ Other

Total # of People in Household: _____ **Total # of Child Dependents in Household:** _____

Is this Visit Court Ordered? ☐ Yes ☐ No

Were you referred to us by another agency? ☐ Yes ☐ No **If Yes, by whom?** _____

Are you affiliated with a Tribe? ☐ Yes ☐ No **If Yes, which Tribe?** _____

Education: Highest Grade Completed? _____ **Are You Currently Enrolled in School?** ☐ Yes ☐ No

(If over 18) Are you registered to vote? ☐ Yes ☐ No **(If No, and you would like assistance registering please let the front office know and someone will assist you.)**

Emergency Contact: _____ **Phone:** _____

Relationship to Client: _____

# of Recent Arrests (last 30 days): _____ **# of Recent DUII Arrests (Last 30 days):** _____

Total # of Arrests: _____ **Total # of DUII Arrests:** _____

State Driver's License number: _____

Special Needs: ☐ Interpreter ☐ Vision Impaired ☐ Hearing Impaired ☐ Mobility Impaired ☐ None ☐ Other: _____

Primary Insurance:

Do you have a primary insurance? ☐ Yes ☐ No

If Yes, Name of Insurance: _____

ID/Policy #: _____

Group #: _____

Policy Holder's Name: _____

Policy Holder's Address: _____

_____

Policy Holders SSN: _____ - _____ - _____

Policy Holder's Date of Birth: _____

Secondary Insurance:

Do you have a secondary insurance? ☐ Yes ☐ No

If Yes, Name of Insurance: _____

ID/Policy #: _____

Group #: _____

Policy Holder's Name: _____

Policy Holder's Address: _____

_____

Policy Holders SSN: _____ - _____ - _____

Policy Holder's Date of Birth: _____

Declaration for Mental Health Treatment:

Details: A form that you can fill out and sign to protect yourself when you may be in a crisis or are unable to make your own treatment decisions. Copies are available for you at the front desk.

Do you currently have a Declaration for Mental Health (MH) Treatment? ☐ Yes ☐ No
If Yes, please bring the document to your next session to review with your counselor.

If No, would you like information about completing a Declaration for MH Treatment? ☐ Yes ☐ No

If Yes, would you like help completing a Declaration for MH Treatment? ☐ Yes ☐ No

Advance Directive:

Details: A written statement of your wishes regarding medical treatment, made to ensure those wishes are carried out should you be unable to communicate them to a doctor.

Do you currently have an Advance Directive? ☐ Yes ☐ No
If Yes, please bring the document to your next session to review with your counselor.

If No, and you would like one please contact your Primary Care Physician (PCP).

If Individual is a Child or Under Supervision of a Care Giver, Please Complete the Following:

Parent/Legal Guardian Giver Name: _____

Parent/Legal Guardian Giver Address: _____

Parent/Legal Guardian Giver Phone: _____

Parent/Legal Guardian Giver Social Security Number: _____ - _____ - _____