Oak Hills
Behavioral Health Solutions, LLC

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Client Information Form

Today's Date: _____

Note: If you have been a client here before, please fill in only the information that has changed. If you are seeking services as a couple, each member must complete an information form (but redundant information can be entered only on one form).

A. Identification:

Your name:
_____

Date of Birth: _____ Age: _____Gender: M F NB

Nickname or aliases: _____Social Security #_____

Billing Address: _____

City: _____State: _____ Zip: _____

Phone(s):
_____

Email(s):
_____

Calls or email will be discreet, but please indicate any restrictions: _____

_____

B. Emergency Information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call? (NOTE: Your emergency person will NOT be contacted except in a genuine emergency.)

Name:

_____

Relationship:_____

Phone 1: _____ Phone 2: _____

C. Referral

How did you find us? Who gave you my/our name to call?

☐ Oak Hills Behavioral Health Solutions website ☐ Other *(please indicate below)*

Name: _____

Contact_____

May we have your permission to thank this person for the referral? ☐ Yes ☐ No

D. Explanation of Insurance and Billing Information:

In Network Coverage: Please contact your insurance provider for applicable copays and deductibles prior to your visit with us. OHBHS will make every reasonable effort to provide you accurate information regarding your expected copay and deductible information. As we do not always receive accurate information during the verification process, you may owe a balance after the claim has been processed and we have received the explanation of benefits (EOB) or the electronic remittance advice (ERA). The balance for in-network coverage will be determined by your insurance provider.

OVERPAYMENT on account: In the event that your account has a credit balance (we owe you money), the financially responsible party has the option to request in writing that the refund amount be paid directly to them or to apply the credit balance toward future copays. This may take up to ten business days for processing and distribution of a check.

If we are an out of network provider, you may be billed the full amount for services and provided a superbill to submit for reimbursement to your insurance provider.

Client Name:_____ Date of Birth:_____

Clinical Information

Presenting Concern: What brings you in today?

Who do you live with?

How would you describe your Family Relationships? Circle all that apply
Positive Encouraging Distant Conflictual Abusive Past Abuse

How would you describe friendships? Circle one:
Sufficient /Several positive supports Minimal/ Few positive supports Isolated
History of poor support system Friends are a negative influence

What do you do for fun?

Developmental Info: Circle All that Apply
Development milestones met on time Premature birth Hearing deficit
Prenatal exposure to alcohol/tobacco/drugs Intellectual delay Speech delay
Visual disability Motor function Delay Social delay Spec. Ed. Held back in school

Abuse History: Circle all that apply
None Current physical Current sexual Current emotional Current neglect
Past physical Past sexual Past emotional Past neglect

Spiritual Affiliation: Circle all that apply

Actively involved in faith community Sporadic involvement Spiritual beliefs without involvement in faith community No identified spiritual or religious affiliations

Legal Status: Probation Officer Parole Officer

Any Arrest History?

Education - Highest Level:

Do you work Full-time work (35 hrs/week)? Part-time work (less than 35 hrs/week)
Unemployed and seeking Unemployed and NOT seeking work

Have you served in the Military?

Current Medical Problems: Circle all that apply
Head Injury High Blood Pressure Diabetes Heart Disease TB Broken Bones Back Problems Asthma Arthritis Headaches Cirrhosis of the Liver Dental Pregnant Disability Medical Hospitalizations

Any Medication Allergies?

Current Medications:

Do any immediate biologically related family members have Mental Health or Substance Use disorders?

Do any extended family have Mental Health or Substance Use disorders?

Have you had Mental Health or Substance Abuse Treatment? Circle all that apply
Therapy Psychiatric hospitalization Residential

Reason for Treatment listed above
Was the Treatment helpful?

If you use substances of abuse, what is/ was your Drug of choice?
How old were you when you first used? How often did/ used?
How do you use it? How much in a day do you use?
Date Last Used

Is there a Secondary drug of choice?
Is there a Third drug of choice?

As far as you know, have you ever hallucinated?

As far as you know, have you had paranoia or other thoughts people may find unusual?

Have you noticed any problems with your memory?

Do you have anyone who helps you with self care?

Would you say your **Appetite** is Decreased? Increased? Normal?
Would you say your **Sleep** is Decreased? Increased? Normal?

Have you ever had thoughts of hurting other people?

Have you ever had thoughts of hurting yourself?

Have you ever done anything to hurt yourself?

Thank you for taking the time to fill out this form