Medicaid Number: _____ Record Number: _____

Client Name: _____ Date of Birth: _____

DAYMARK Recovery Services

Patient Information Sheet **Date Completed _____**

First Name:	Middle:	Last Name:
Preferred Name:	Previous First Name:	Previous Last Name:
Street address:		County of Residence:
City:	State:	Zip code:
Mailing address: ☐ Do not mail		
City:	State:	Zip code:
Date of Birth:	Social Security:	Birth Sex: ☐ Female ☐ Male

Current Gender:	Gender Identity:	Sexual Orientation:	Preferred Pronoun:
☐ Female ☐ Male ☐ Undifferentiated	☐ Female ☐ Male ☐ Female-to-male/Transgender Male ☐ Male-to-female/Transgender Female ☐ Genderqueer ☐ Other ☐ Choose not to disclose	☐ Straight/Heterosexual ☐ Lesbian, gay, or homosexual ☐ Bisexual ☐ Other ☐ Choose not to disclose ☐ Don't know	☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Ze/hir ☐ Other ☐ Decline to answer ☐ Asked but unknown

METHODS OF CONTACT

Home phone: ☐ n/a Enter phone # below:	Cell Phone: ☐ n/a Enter phone # below:	Day/Work Phone: ☐ n/a Enter phone # below:	Alternate Phone: ☐ n/a Enter phone # below:	Secondary Phone: ☐ n/a Enter phone # below:
Leave message? ☐ Y ☐ N	Leave message? ☐ Y ☐ N	Leave message? ☐ Y ☐ N	Leave message? ☐ Y ☐ N	Leave message? ☐ Y ☐ N

Email address: ☐ n/a

Preferred Contact Order: (Write 1, 2, 3, 4, or 5 next to each item to indicate which number to call first, second, third, etc)

_____ Home _____ Cell _____ Day/Work _____ Alternate _____ Secondary

EMERGENCY CONTACT INFORMATION	**LEGALLY RESPONSIBLE PERSON**
Name:_____	☐ Self ☐ Parent ☐ Legal Guardian ☐ Other: _____
Relationship:_____	Name:_____
Address:_____	Address: _____
City/State:_____ Zip Code:_____	City/State:_____ Zip Code: _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone: _____

Primary Care Practice: _____ **Preferred Hospital**: _____

Date of last visit with your Primary Care Practice: _____ ☐ Don't have a Primary Care Practice

Preferred Pharmacy Name: _____ **Pharmacy Address/Phone:** _____

Medicaid Number: _____ Record Number: _____

Client Name: _____ Date of Birth: _____

ETHNICITY (check one) ☐ Hispanic-Mexican American ☐ Hispanic-Puerto Rican ☐ Hispanic-Cuban ☐ Hispanic-Other ☐ Not Hispanic	**RACE** (check one) ☐ Black/African American ☐ White/Anglo/Caucasian ☐ Amer Indian/Native American ☐ Alaska Native ☐ Asian ☐ Pacific Islander ☐ Multiracial ☐ Other : _____	**MARITAL STATUS** (check one) ☐ Annulled ☐ Single (never married) ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partners	**Primary Language** (check one) ☐ English ☐ Sign Language ☐ French ☐ Spanish ☐ Other **English Proficiency** (Do you need an interpreter?) ☐ Yes ☐ No
Employment Status (check one) ☐ Unemployed ☐ Employed Full time ☐ Employed Part Time ☐ Student ☐ Retired ☐ Homemaker ☐ Not available for work ☐ Armed Forces ☐ Seasonal/Migrant worker Employer: _____ Occupation:_____	**Self-Help Programs** (check one) How often have you attended a self-help program in the past 30 days? ☐ None in past month ☐ 1-3 times ☐ 4-7 times ☐ 8-15 times ☐ 16-30 times ☐ Some attendance, don't know number	**Living Arrangement** (check one) ☐ Private Residence ☐ Other independent housing ☐ Homeless shelter ☐ Correctional facility ☐ Institution ☐ Residential Facility (excluding nursing homes) ☐ Foster family/alternative family living ☐ Nursing home ☐ Adult care home 7+ beds ☐ Adult care home 1-6 beds ☐ Community ICF-MR ☐ Comm. ICF-MR,70+ beds ☐ Other: _____	**Referral Source** (check one) ☐ Self/no referral ☐ Family/friends ☐ Other outpatient/ residential facility ☐ State facility ☐ Psychiatric service/ general hospital ☐ Non-residential treatment/ habilitation program ☐ Private Physician ☐ Nursing home ☐ Veteran's Administration ☐ Other health care ☐ Community Agency ☐ Court/corrections/prisons ☐ School ☐ Other:_____
Education: Highest Grade Completed or GED or Degree: _____	**Number of Arrests in past 30 days** (include arrest for any cause regardless of current status): _____		
Family Size (number of people living in household, for whom you are financially responsible, including yourself): _____	**Annual Family Income** $_____.00	**Are you a veteran?** ☐ Yes ☐ No	**Females Only:** **Currently Pregnant?** ☐ Yes ☐ No

Insurance Coverage

Medicaid	Yes ☐	No ☐	ID Number:
Medicare	Yes ☐	No ☐	ID Number:
Blue Cross Blue Shield	Yes ☐	No ☐	ID Number:
United Healthcare	Yes ☐	No ☐	ID Number:
Humana	Yes ☐	No ☐	ID Number:
Cigna	Yes ☐	No ☐	ID Number:
Aetna	Yes ☐	No ☐	ID Number:

The following questions are being asked to help identify if you need assistance for which a referral can be provided

1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?	**No**	Yes, current need/concern	Yes, in past 12 months but NOT current need/concern
2. Within the past 12 months did the food you bought just not last and you didn't have money to get more?	**No**	Yes, current need/concern	Yes, in past 12 months but NOT current need/concern
3. Do you have housing (a place to live)?	**No**	**Yes**	
4. Are you worried about losing your housing?	**No**	Yes, current need/concern	Yes, in past 12 months but NOT current need/concern

CONTINUED ON NEXT PAGE

Medicaid Number: _____ Record Number: _____

Client Name: _____ Date of Birth: _____

5. Within the past 12 months, have you or your family members you live with been unable to get utilities (heat, electricity) when it was really needed?	**No**	Yes, current need/concern	Yes, in past 12 months but NOT current need/concern
6. Within the past 12 months, has lack of transportation kept you from medical appointments, getting your medicines, non-medical meetings or appointments, work, or from getting things that you need?	**No**	Yes, current need/concern	Yes, in past 12 months but NOT current need/concern
7. Do you feel physically and emotionally safe where you currently live?	**No**	**Yes**	
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?	**No**	Yes, current need/concern	Yes, in past 12 months but NOT current need/concern
9. Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?	**No**	Yes, current need/concern	Yes, in past 12 months but NOT current need/concern
10. In the past 12 months, have you had trouble affording health insurance (such as deductibles, co-payments, etc.)	**No**	Yes, current need/concern	Yes, in past 12 months but NOT current need/concern
11. In the past 12 months, have you had trouble paying for or accessing medications?	**No**	Yes, current need/concern	Yes, in past 12 months but NOT current need/concern
12. In the past 12 months, have you had concerns over obtaining or maintaining employment?	**No**	Yes, current need/concern	Yes, in past 12 months but NOT current need/concern

Would you like to share anything additional related to your needs or concerns?

Adult Client-3 Month Update

1. How would you rate your ability to deal with **daily problems now**?

1 ☐ Much better 2 ☐ A little better 3 ☐ About the same 4 ☐ A little worse 5 ☐ Much worse ☐ **NA-New or Child client**

2. In general, how would you rate **your overall health** now?

1 ☐ Excellent 2 ☐ Very good 3 ☐ Good 4 ☐ Fair 5 ☐ Poor ☐ **NA-New or Child client**

Parent/LRP with Child Client-3 Month Update

1. How would you rate your child's ability to deal with **daily problems now**?

1 ☐ Much better 2 ☐ A little better 3 ☐ About the same 4 ☐ A little worse 5 ☐ Much worse ☐ **NA-New or Adult client**

2. In general, how would you rate **your child's overall health** now?

1 ☐ Excellent 2 ☐ Very good 3 ☐ Good 4 ☐ Fair 5 ☐ Poor ☐ **NA-New or Adult client**

To the best of my knowledge, the questions on this form have been answered accurately. I understand it is my responsibility to inform DAYMARK, in writing, when I desire changes in this information, including the method of contacting me.

Completed by: _____ Date: _____

(If not client, list relationship)