Intake/annual Checklist

Please complete the following to see what forms need to be completed:

All highlighted fields must be completed for list to generate below.

Format: Paper

Age Group	Please Select
Substance Use Diagnosis	Please Select
HIV Diagnosis	Please Select
Insurance	Please Select
Has a Guardian	Please Select
Services Needed	Please Select
Visit Type	Please Select
Rendering SB&H Staff is Licensed	Please Select
Recommended Steps	
Completed	0

Intake Consents & Steps	Required (If Applicable)	Location	Completed
Consent Packet Acknowledgement		Axiom/Excel	
SUD Release		Axiom/Excel	
Advance Directives		Axiom/Excel	
PCP ROI		Axiom/Excel	
School ROI		Axiom/Excel	
JPO ROI		Axiom/Excel	
External BH provider ROI		Axiom/Excel	
Family/Friends ROI		Axiom/Excel	
Dual Enrollment- OTP specific		Axiom/Excel	
Transport Authorization- youth specific		Axiom/Excel	
Copy of Insurance Card		Axiom - Scanned documents	
Private Pay Agreement		Confluence	
Copy of Birth Certificate, Notice to Provider (DCS Only), or Proof of Guardianship		Axiom - Scanned documents	
Copy of Member ID or Birth Certificate		Axiom - Scanned documents	
Create Chart in Axiom		Axiom - Scanned documents	

Screening Forms	Required?	Location	Completed
Cover Sheet		Axiom/Excel	
Demographic [834]		Axiom	
Adult Health Risk Assessment [HRA]		Axiom/Excel	
Youth Health Risk Assessment [HRA]		Axiom/Excel	
PCP Medical History Form		Axiom/Paper	
Depression Screener [PHQ-9]		Axiom/Paper	
Anxiety Screener [GAD-7]		Axiom/Paper	
ADHD Screener		Axiom/Paper	

Assessment Forms	Required?	Location	Completed
Engagement Session Note [Assessment]		Axiom	
Substance Use Screener [ASAM]		Axiom	
Service Plan		Axiom	
Support & Safety Plan		Axiom	
ART/CFT/Staffing Plan		Axiom	
Developmental History Assessment		Axiom	
Columbia-Suicide Serverity Rating Scale		Axiom	
CALOCUS		CALOCUS Portal	
Strength Needs Culture Discovery [SNCD]		Axiom	
PCP Note 3.0		Axiom	

Wrap Up	Required?	Location	Completed
Overview of next steps		Confluence	
PCP Communication		Axiom	
Birth to 5 Observations Scheduled		Axiom - scheduling	
Nursing Assessment Scheduled		Axiom - scheduling	
Therapy Appointment Scheduled		Axiom - scheduling	
Psych Eval Scheduled		Axiom - scheduling	
PCP Visit Scheduled		Axiom - scheduling	
Copies of Service Plan and Support & Safety Plan given to member		Axiom	
Pend Engagement Session Note and Service Plan to BHP		Axiom	
Document Closed		Axiom	

Southwest Behavioral & Health Services

Intake/Annual Consent Packet Acknowledgement

Member's Name	SSN	DOB

Address, City, State Zip	Phone

I have received a copy of the Southwest Behavioral and Health Services Consent Packet, summarized below. I understand each form as they have been presented to me and agree to expectations and guidelines. I have been offered the opportunity to review the below consent forms and understand that I have the ability to ask questions to my satisfaction as part of the SB&H intake process. I understand that a copy of this page will be placed in my clinical record to show that I received the contents of this document.

☐ Consent for Evaluation and/or Treatment (SB&H Handbook)

☐ **I hereby attest and acknowledge that I have read this entire consent for evaluation and/or treatment agreement and expressly declare, confirm and certify that I have the authority to execute this agreement on behalf of myself or applicable minor pursuant to any and all of the terms and conditions identified as expressed within this Agreement. I have had ample opportunity to review the contents of this Agreement and hereby authorize SBH to proceed based upon my authority to grant SBH the ability to evaluate and/or treat myself or applicable minor. I unequivocally expressed and represented my ability and authority to grant SBH the right to so proceed.**

☐ Informed Consent to Participate in Telepractice Services (SB&H Handbook)

☐ I agree ☐ I do not agree to participate in telepractice services

☐ Consent for Communication ☐ Email ☐ Voicemail ☐ Text Messages

☐ Attendance Guidelines Agreement (SB&H Handbook)

☐ Health Plan Member Handbook Acknowledgement (links in SB&H handbook)

☐ Payment Agreement: *I give my consent for SBH to bill my insurance carrier for services provided per the Notice of Privacy Practices referenced below. I elect to receive services with the understanding that I <u>may</u> be personally responsible to pay for the service being rendered to me.* (SB&H Handbook)

☐ SB&H Member Handbook Acknowledgement *(Program Responsibilities, List of Available Services at SB&H, Service Planning, Transition/Discharge Planning, Fees, Safety, SB&H Code of Ethics, SB&H Notice of Privacy Practices, AHCCCS Notice of Privacy Practices, Confidentiality of Substance Abuse Records, Rights of Persons Served, Additional Rights for Inpatient or Residential Treatment Facilities, Legal Rights for Persons with Serious Mental Illness, Notice to Persons with Serious Mental Illness, Notice to Individuals Receiving Substance Abuse Services, Grievance, Appeal and Complaint Policy and Procedure*). **Bureau of Medical Facilities Licensing**: 602-364-3030; **Bureau of Behavioral Health Facilities Licensing**: 602-542-3422.

Signature of Member	Date

Signature of Parent, Guardian, or authorized representative (when required)	Date
Witness (Staff) Signature	Date

Member's Name: DOB:

Authorization to Release Substance Abuse Disorder Records for Payment/Operations

I, _____ _____ _____
Member's Name SSN DOB

_____ _____
Address, City, State Zip Phone

Authorize Southwest Behavioral Health Services to release to: (Check all that apply)

☐ AHCCCS for disclosure of my demographics

☐ Payment for my treatment to my Health Plan

☐ AzComplete Health ☐ Banner University ☐ Care1st ☐ Health Choice
☐ United Healthcare ☐ Mercy Care ☐ Magellan

☐ Other: _____ (Please specify)

The purpose of this release is to provide only the necessary information for payment of services to your health plan and/or to provide demographics to Arizona Health Care Cost Containment System (AHCCCS).

Notice to Recipient

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a Member as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any Member with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

I understand that at any time, I may revoke this authorization by writing to SBH in keeping with SBH Policies and Procedures. The revocation will be effective except to the extent that action based on this authorization has already been taken. You are referred to the SBH Notice of Privacy Practices for further information regarding your rights under federal law (HIPAA: 45 CFR 160-164).

Authorization will expire:

☐ 1 Year From this Date

☐ Other: _____ (Enter Date, no greater than 1 year)

_____ _____
Signature of Member Date

_____ _____
Signature of Parent, Guardian, or authorized representative (when required) Date

Member's Name: _____ *DOB:* _____

Advance Directive Durable Mental Health Care Power of Attorney Form

General Instructions: You may use this Advance Directive Durable Mental Health Care Power of Attorney form if you want to appoint a person to make future mental health care decisions for you if you become incapable of making those decisions for yourself. **The decision about whether you are incapable can only be made by an Arizona licensed psychiatrist or psychologist who will evaluate whether you can give informed consent.** Be sure you understand the importance of this document. Talk to your family members, friends, program staff members and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctor, clergyperson and a lawyer before you sign this form.

If you decide this is the form you want to use to develop an Advance Directive Durable Mental Health Care Power of Attorney, complete the form. Do not sign the form until your witness or notary and a program staff member are present. You will be asked to place a copy of the form in your clinical record so that we and other providers will follow your wishes if you become incapacitated. You and your representative should retain a copy of this document for your future reference. **At a minimum, you and an SBH Staff Member must sign #2 or #3 below to confirm that you understand your rights and you have been offered a copy of the form.**

1. Information about me:

Name: _____ Age: _____

Address, City, State Zip: _____ Date of Birth: _____

Telephone: _____

2. I decline to exercise my Advance Directive Durable Mental Health Care Power of Attorney at this time. If I choose to exercise this right, at a later time, I will notify the SBH staff member who is responsible for coordinating my services.

_____ _____

Signature of Member Date

_____ _____

SB&H Staff Member Date

3. My Advance Directive Durable Mental Health Care Power of Attorney is made pursuant to Arizona law, and continues in effect for all who may rely on it except to those I have given notice of its revocation pursuant to Arizona law.

_____ _____

Signature of Member Date

_____ _____

SB&H Staff Member Date

4. Notification to Primary Care Physician (SBH personnel only)

☐ Mailed ☐ Faxed ☐ Emailed Date: _____ By whom: _____

Note: Retain copy in person's comprehensive clinical record (Do not purge from record).

Member's Name: _____ *DOB:* _____

STOP: Only complete following sections if the member has an Advance Directive!

5. Selection of my mental health care representative and alternate:
I choose the following person to act as my representative to make mental health care decisions for me when I am incapable of making them for myself.

Name:		Telephone:	
Address, City, State Zip:		Work Phone	
		Cell Phone	

I choose the following person to act as my alternate representative to make mental health care decisions for me if my first representative is unavailable, unwilling, or unable to make decisions for me.

Name:		Telephone:	
Address, City, State Zip:		Work Phone	
		Cell Phone	

6. Mental health treatments that I AUTHORIZE if I am unable to make decisions for myself:

Here are the mental health treatments I authorize my mental health care representative to make on my behalf if I become incapable of making my own mental health care decision due to mental or physical illness, injury, disability or incapacity. If my wishes are not clear from this Advance Directive Durable Mental Health Care Power of Attorney or are not otherwise known to my representative, my representative will, in good faith, act in accordance with my best interests. This person will represent me until it is revoked by me or by an order of a court. My representative is authorized to do the following, which **I have initialed or marked:**

☐ **About my records:** To receive information regarding mental health treatment that is proposed for me and to receive, review and consent to disclosure of any of my medical records related to that treatment.

☐ **About medications:** To consent to the administration of any medications recommended by my treating physician.

☐ **About a structured treatment setting:** To admit me to a structured treatment setting with 24-hour-a-day supervision and an intensive treatment program licensed by the Department of Health Services, which is called a “level one” behavioral health facility.

Additional Directives regarding my mental health treatment are: (See also www.mentalhealtrecovery.com/crisis.html for assistance)

☐ My Wellness Recovery Action Plan
☐ Contact Person(s)
☐ Possible causes of my crisis
☐ Ways to help avoid hospitalization

Member Name:

Note: One adult must witness or notarize the signing of this document and then sign it. The witness cannot be anyone who is: (a) under the age of 18; (b) related to you by blood, adoption or marriage; (c) entitled to any part of your estate; (d) appointed as your representative; or (e) involved in providing your health care at the time this document is signed (SBH employees are not permitted to witness document signing but may notarize the document).

Witness: I affirm that I personally know the person signing this Advance Directive Durable Mental Health Care Power of Attorney and that I witnessed the person sign or acknowledge the person's signature on this document in my presence. I further affirm that he/she is to be of sound mind and not under duress, fraud, or undue influence. He/she is not related to me by blood, marriage or adoption and is not a person for whom I directly provide care in a professional capacity. I have not been appointed as the representative to make mental health treatment decisions on his/her behalf.

Witness Name (Printed): _____

Witness Address: _____

_____ _____

Witness Signature Date & Time

OR

On this ____ day of _____, _____ (Year) before me, _____, the undersigned Notary Public, personally appeared _____.

_____ _____

Notary Signature Date

My commission expires: _____

SB&H Staff Name (Printed): _____

_____ _____

SB&H Staff Signature Date & Time

Member's Name: _____ *DOB:* _____

Representatives Acceptance of Appointment

I accept this appointment and agree to serve as representative to make mental health treatment decisions for 0. I understand that I must act consistently with the wishes of the person I represent as expressed in this Advance Directive Durable Mental Health Care Power of Attorney or, if not expressed, as otherwise known by me. If I do not know the Individual's wishes, I have a duty to act in what I, in good faith, believe to be that person's best interests. I understand that this document gives me the authority to make decisions about mental health treatment only while (insert individual's name) has been determined to be incapacitated which means under Arizona law that a licensed psychiatrist or psychologist has the opinion that the individual is unable to give informed consent.

Representative Name (Printed): _____

_____ _____

Representative Signature | Date & Time

Alernate Representative Name (Printed): _____

_____ _____

Alternate Representative Signature | Date & Time

Note: Retain a copy in the member's comprehensive clinical record.

Southwest Behavioral & Health Services

Release of Information and Records Request Form

Please check only **ONE** of the following options:

☐ Check here if you would like to **Release/Send** your records ☐ Check here if you would like to **Request** your record

☐ Check here if you would like to **both Release AND Request** your records

How would you like to receive your records? Please select: ☐ Mail ☐ Digital format via Mail (50 page minimum required) ☐ Email: _____

Dates of Service (for records to be sent): ☐ past 60 days ☐ past 90 days ☐ past year

☐ Other (list date range): _____ to _____

I, _____ _____ _____

Member's Name SSN DOB

_____ _____

Address, City, State, Zip Phone Number

Authorize releases, and/or record requests as selected herein between:

Southwest Behavioral & Health Services	602-265-8338
Name of Healthcare Organization with Treatment Relationship	Phone Number
3450 N. 3rd Street, Phoenix, AZ 85012	602-323-2351
Address, City, State, Zip	Fax Number

AND

Name of Person and Agency (Recipient)	Phone Number
Address, City, State, Zip	Fax Number

Notice to Recipient: This information has been disclosed to you from records that Federal law protects. These records are not subject to redisclosure. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of Substance Abuse information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. I understand that if this information is released to the indicated third party, the third party may not follow the Federal privacy laws and my personal health information may be released by the third party. **Treatment, payment, and/or enrollment is not conditioned upon whether the member signs this consent.**

Note: Federal and state government rules require a separate authorization be completed for each of the following categories: Information on HIV/AIDS and other communicable diseases, and Alcohol/Substance Abuse Records.

What kind information would you like released and/or requested as selected herein? Check all that apply:

☐ Clinical Assessment	☐ Psychiatric Evaluation	☐ Medications
☐ Clinical Services Notes	☐ Treatment/Service Plans	☐ Test Results/Labs
☐ Discharge Summary	☐ Substance Use Information	☐ AIDS/HIV Information
☐ Psychological Assessment	☐ Verbal disclosure of treatment information	☐ School Records

☐ Other (Please specify i.e. billing records, treatment summary, etc): _____

Purpose for Release/Request: _____

A purpose for the request/disclosure is required for all 3rd party releases only. This section identifies to the authorized party and signer why the records are being requested and/or what the records will be used for. The purpose is not required when members are requesting their own records. **I understand** that at anytime, I may revoke this authorization by writing to SBH in keeping with SBH Policies and Procedures. The revocation will be effective except to the extent that action based on this authorization has already been taken. You are referred to the SBH Notice of Privacy Practices for further information regarding your rights under federal law (HIPAA: 45 CFR 160-164).

Authorization will expire:

☐ 1 Year From this Date

☐ Other: _____ (Enter Date, no greater than 1 year)

_____ _____

Signature of Member/Guardian/Authorized representative Date

_____ _____

Other Required Signature (If Applicable) Witness (if Member is unable to sign)

If patient is between 12-17 years of age, both his/her signature and the signature of parent/legal guardian may be required

Dual Enrollment Prevention by Fax (ARIZONA)

Instructions: Member to complete form as part of SB&H intake process. SB&H team to fax completed authorization to all applicable OTPs within a 200-mile radius SAMHSA OTP Directory; then scan document with the fax confirmation into the member's chart as "Faxed Dual Enrollment Prevention".

In compliance with all state and federal regulations (including CFR Part 2) this consent authorizes Southwest Behavioral & Health Services (SBH) to use and disclose Protected Health Information (PHI) with all applicable Opioid Treatment Programs (OTPs) within the designated radius of the clinic listed below.

Member Name

AHCCCS ID

DOB

SSN

Address, City, State Zip

Phone

SBH Site	
Bullhead City ORS	
Flagstaff ORS	
Prescott Valley ORS	
7th AVE ORS	

Member Notification

The above-mentioned clinic is required to notify each member prior to admission that it cannot provide treatment or medication to a member who is simultaneously receiving these same services from another treatment program, unless the medication is being provided in response to an emergency or disaster that forced the closure of the member's regular home clinic.

Purpose of Disclosure

The purpose of this disclosure Is to prevent a member from dual enrollment inn other Opioid Treatment Programs (OTPs)/Medication Assisted Treatment (MAT) programs. This is completed by notifying local OTPs within a 200-mile radius of the above-mentioned clinic, via secure facsimile transmission, that the identified member is enrolled in SBH's Medications for Opioid Use Disorder (MOUD) program.

Information to be Disclosed

Information related to disclosure to prevent multiple enrollments is permitted by 42 CFR Part 2. If it is confirmed that member is receiving duplicative services the information to be disclosed may include the member's demographic Information (e.g., full legal name, alias, last four numbers of social security number, date of birth, admission date, medication type/form/dose, discharge date and reason, and last dose of medication) and may include records related to substance use, communicable diseases, mental health, medical history, and physical treatment.

Storage of Information and Confidentiality

Member records/information is protected under federal regulations governing Confidentiality of Alcohol and DrugAbuse Patient Records, including 42 CFRPart 2, the Health Insurance Portabilityand Accountability Act of 1996 ("HIPAA"), and 45 CFR Parts 160-164. The recipientof the Information may re-disclose the information, and it may no longer be protected by the HIPAA privacy law. However, 42 CFR Part 2 will continue to protect the confidentiality of information that identifies the member as a patient in an alcohol or other drug program from any re-disclosure.

Programs To Receive Disclosed Information and Means of Disclosure

The information is disclosed to all OTPs/MATs programs within a 200-mile radius of the above-mentioned clinic via secure facsimile transmission.

Terms of This Consent

The above-mentioned member's records are protected under the Federal Confidentiality Regulations and may not be disclosed without the member's express written consent, unless otherwise provided for in the regulations; and the client may revoke this consent at any time except to the extent that action has been taken in accordance with it, and in any event, this consent expires automaticallyas set forth below.

This is a limited disclosure for the purposes described above, and so indicated by the person whose records this information has been extracted from.

The member may view and request a copy of the information described above and/or in this form.

This consent will expire 90 days from discharge of the program unless otherwise indicated below.

☐ By selecting this option, this consent will expire on: _____ (specify date)

Member Acknowledgement:

By signing below,
I confirm that I have thoroughly read and understand the Information outlined in this document and attest to the following statements:

- I am not receiving medication and/or treatment from another Opioid Treatment Program/Medication Assisted Treatment facility, its satellite, or an Office Based Opioid Treatment provider.
- I release the above-mentioned clinic from liability which may arise as a result of information disclosed under this authorization if such information disclosed is later used to my detriment.
- I understand if I do not sign this statement, I will not be admitted for treatment or provided emergency medication services.
- I understand that I have the right to revoke this consent, in writing. at any time by sending such written notification to Southwest Behavioral & Health Services (SBH).
- **I permit all opioid treatment programs within a 200-mile radius of the above-mentioned clinic to disclose information Indicated on this form.**

Member Signature	Date
Parent, Guardian Signature	Date
Staff/Witness Signature	Date

Receiving OTP

A response is requested only if the receiving OTP has Information that the above-named member may also be enrolled in the receiving clinic's OTP services. If the above-named member Is currently enrolled with your clinic, please contact the Southwest Behavioral & Health Services (SBH) clinic listed below via fax or phone to provide information regarding the member's enrollment with your organization.

SBH Site	Address
Bullhead City ORS	809 Hancock Road #1, Bullhead, AZ 86442 P:928-763-7111 F: 928-542-4031
Flagstaff ORS	1515 E. Cedar Avenue #E-2, Flagstaff, AZ 86004 P:928-714-0010 F: 928-714-0024
Prescott Valley ORS	7600 E. Florentine Road Ste. 101 Prescott Valley, AZ 86314 P:928-775-7088 F:928-775-7099
7th AVE ORS	1424 S. 7th Ave, Bldg. C. Phoenix, AZ 85007 P: 602-258-3600 F: 602-256-0514

Notice to recipient:

Any substance use disorder treatment information disclosed under this authorization has been disclosed from records that may be protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit the recipient from making any further disclosureof this information unless further disclosure is exclusively permitted by the written consent of the person to whom it pertains or otherwise permitted 42 CFR Part2. A general authorization for the release of medical or other Information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any substance use disorder patient

Communicable disease-related information, pursuant to this release, cannot be re-disclosed without specific written authorization. (A.R.S. 36-664.H.)

SOUTHWEST
BEHAVIORAL&HEALTH SERVICES
IMPACTING PEOPLE, IMPROVING COMMUNITIES

Southwest Behavioral & Health Services Cover Sheet

Member's Name | Member SS# | DOB

Address, City, State Zip | Phone | Email

Gender: ☐ Gender Variant ☐ Male ☐ Female ☐ Intersex ☐ Questioning ☐ Transgender ☐ Decline to answer

Race: ☐ American Indian/Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ Caucasion ☐ Native Hawaiian ☐ Decline to answer

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline to answer

Primary Language | Preferred Language

Insurance Coverage: *Attach a copy of medicaid, medicare, commercial and other insurance cards*

☐ Medicaid ☐ Medicare ☐ Private (Self-pay) ☐ TriCare ☐ Blue Cross ☐ HMO ☐ Other

Insurance Co. | Insurance ID# | Policy#

Special Needs:

Interpreter (spoken)	☐ No	☐ Yes, specify language	
Translator (written)	☐ No	☐ Yes, specify language	
Mobility Assistance	☐ No	☐ Yes, identify assistance needed	
Visual Impairment Assistance	☐ No	☐ Yes, identify assistance needed	
Hearing Impairment Assistance	☐ No	☐ Yes, identify assistance needed	
Need Childcare Arrangements	☐ No	☐ Yes, identify need	

Are there known impairment(s) that require special assistance to participate in the assessment/service planning process. ↓

Key Contacts: ☐ No ☐ Yes

If applicable, select custody arrangement ☐ Sole ☐ Joint ☐ Ward of Court (DCS) or Legal Guardian

Parent/Legal Guardian(s): Phone

Must provide current legal document Phone

Phone

Phone

Emergency Contact: Phone

Complete ROI Address

PCP/Physician: Phone Fax

Complete PCP ROI Address

Dentist: Phone Fax

Other Healthcare Specialist(s): Phone Fax

(e.g. Mental health, substance use, OBGYN, neuro, pain, naturopath, etc) Address

Phone Fax

Address

Pharmacy: Address

Other Key Contacts: *(e.g. school, probation/parole officer, other involved agencies [DDD/DCS], significant other, neighbors, family)*

Name: Relationship:

Phone: Fax:

Name: Relationship:

Phone: Fax:

Southwest Behavioral & Health Services Adult Health Risk Assessment

Member's Name | Member SS# | DOB

Address, City, State Zip | Phone | Email

Substance Related Disorders Screening ☐ Adult (18+) ☐ Youth (0-17)

During the past year, have you ever drank or used drugs more than you meant to?	☐ No	☐ Yes
Have you ever neglected some of your usual responsibilities because of alcohol or drugs?	☐ No	☐ Yes
Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	☐ No	☐ Yes
Has family, friends, or anyone else ever told you they objected to or were concerned about your alcohol or drug use?	☐ No	☐ Yes
Have you ever found yourself thinking a lot about wanting to use alcohol or drugs?	☐ No	☐ Yes
Have you ever used alcohol or drugs to relieve emotional discomfort such as sadness, anger or boredom?	☐ No	☐ Yes

Who in your family uses alchohol or other substances?

Please list any history and treatment of behavioral health or substance use issues that your family members have had:

Adult Health Risk Screening Questionnaire

Have you been diagnosed with diabetes, asthma, or high blood pressure?	☐ No	☐ Yes
If yes, what medications are you taking for this?		
Have you had a blood pressure reading of 140/90 or higher in the last year?	☐ No	☐ Yes

Check the symptoms you experience regularly:

☐ High Cholesterol ☐ Chest Pain ☐ Nausea/Vomiting ☐ Headaches ☐ Dizziness
☐ Extreme Fatigue ☐ Blurry Vision ☐ Over/Under Weight ☐ Other:

Do you eat a poor diet?	☐ No	☐ Yes
Are you sedentary or minimally active?	☐ No	☐ Yes
Do you use tobacco? If so, what and how often?	☐ No	☐ Yes

☐ None ☐ Vape ☐ Cigarettes ☐ Chew
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Health History (Please include all medical, dental, and behavioral health history)

☐ PCP on file Date of last Physical Visit Current health issues

Any Allergies? ☐ No ☐ Yes Please Specify

☐ Dentist on file Date of last Dental Visit Current oral issues

☐ Other: Date of last Visit Other health issues

☐ Other: Date of last Visit Other health issues

Untreated physical and/or behavioral needs can impact overall health and negatively impact progress toward Goals.

A PCP appointment is recommended for further evaluation.

Would you like help with the above or other physical health needs?	☐ No	☐ Yes

Return to Intake Checklist