HUMAN SERVICE AGENCY CLIENT QUESTIONNAIRE

Client's Name: First: _____ MI: ___ Last: _____ Gender: ☐ Male ☐ Female

Maiden Name: _____

Mailing Address: _____ City: _____ STATE: ___ Zip: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Email: _____

Date of Birth: _____ Social Security #: _____ County of Residence: _____

First two letters OF YOUR MOTHER'S FRIST NAME: (*used in creation of a unique ID number*): ____

Emergency Contact:

Relationship to you:

Phone: (Home) _____

(Work)_____

(Cell)_____

Person responsible for payment: _____

Social Security #: _____

Mailing Address: _____

Phone: (Home) _____

(Work) _____

(Cell) _____

Do you have: Insurance ○ Yes ○ No (If yes, please bring your insurance card with you and contact your insurance company regarding coverage and if pre-authorization is required).

Medicare ○ Yes ○ No (If yes, please bring your card)

Medicaid ○ Yes ○ No (If yes, please bring your Medicaid card; if you are Medicaid Managed Care, please see that either you or your doctor supply us with the referral card prior to your appointment)

Employee Assistance Program (EAP): ○ Yes or ○ No If yes, with who_____

Hispanic Ethnicity: (please check one)

- O Cuban
- O Hispanic-SPECIFIC ORGIN NOT SPECIFIED
- O Mexican
- O Not of Hispanic Origin
- O Other specific Hispanic
- O Puerto Rican

Race: (please check one)

- O Alaska Native
- O American Indian
- O Asian
- O Black or African American
- O Native Hawaiian/Pacific Islander
- O Other
- O White

Adult Living Arrangements: (18 and over-please check one)

- O Adult Foster Care
- O Alone/Independent Living
- O Group Home
- O Homeless
- O Nursing Home
- O Other
- O Other Public/Private
- O Supportive Living
- O Transitional Facility
- O With Children
- O With other Family member
- O With Parent
- O With Spouse and Children
- O With Spouse
- O With Unrelated Person

OR

Adolescent Living Arrangements: (under 18-please check one)

- O Both Parents
- O Foster Home
- O Homeless
- O Independent Living
- O Other
- O Other Relative
- O Parent – Step-Parent
- O Private Care Facility
- O Public Care Facility
- O Single Parents
- O Therapeutic Foster Home

**Answer only if HOMELESS was checked on Living Arrangements:

- O 4 or more Homeless episodes in past 3 years
- O Continually Homeless for a year or more
- O Homeless but 1 or 2 not applicable

Do you understand English? (Please check one)

- O Full
- O Limited
- O Requires Assistance

What is your preferred language: (if other, please list)

- O English
- O Spanish
- O Other _____

Do you work?

- O Full-time
- O Part-time
- O Not in the labor force
- O Unemployed

What is your occupation: (Only needed if not in Labor Force was check)

- O Disabled
- O Homemaker
- O Inmate of Institution
- O Not Applicable
- O Other
- O Retired
- O Student

Employment Length: (please check one)

- O Less than 6 months
- O 6 months but less than 1 year
- O 1 year
- O 2-4 years
- O 5-7 years
- O 8-15 years
- O 16-20 years
- O 21 or more years

Marital Status: (please check one)

- O Divorced
- O Never married
- O Now Married
- O Separated
- O Widow

Are you a Veteran? (please check one)

- O Yes
- O No

What is the highest grade you completed in school? (enter a number) _____

Are you in Special Education?

- O Yes
- O No

Who referred you to the Human Service Agency? (please check one)

- O Alcoholic Anonymous/Alateen
- O Alcohol/Drug Provider
- O Bureau of Indian Affairs
- O Child/Day Care Provider
- O Clergy
- O College/University
- O Community Hospital
- O Community Mental Health Center
- O County Board of Mental Illness
- O Court/Criminal Justice Referral
- O Department of Social Services
- O Department of Disability Agency
- O Division of Alcohol/Drug Abuse
- O Employee/EAP
- O Family/Self-Referral/Friend
- O Financial Counseling
- O Gambling Anonymous
- O Human Service Center
- O Indian Health Services
- O Information and Referral Hotline
- O Medical Physician
- O Narcotic Anonymous
- O Nursing Home
- O Other
- O Other Healthcare Provider
- O Other Social Services
- O Private Mental Health Professional
- O Public Health Nurse/Dept of Health
- O Public Health Services
- O School (Primary/Secondary)
- O Veterans Administration
- O Vocational Rehabilitation

Criminal Justice Referral (Only needs to be filled out if Court/Criminal Justice Referral was checked above)

- O Attorney
- O Department of Corrections
- O Diversionary Program
- O DUI/DWI
- O Federal Probation
- O Law Enforcement
- O Not Applicable
- O Other
- O Other Court (Not State or Federal)
- O Other Recognized Legal Entity
- O Prison
- O Probation/Parole
- O State's Attorney
- O State/Federal Court
- O Unknown

What is your smoking status/history? (required if over 13 years old)

- O Current every day smoker
- O Current some day smoker
- O Former smoker
- O Never a smoker
- O Smoker, current status unknown
- O Unknown if ever smoked

How did you hear about our facility: (please check one)

- O Client of HSA
- O Friends and Family
- O Radio
- O Newspaper
- O Yellow Pages
- O Other

How would like to be reminded of your appointment?

- O Cell text message (Cell #) _____ Cell Service Provider (AT&T, etc)_____
- O Email address _____
- O Phone message (phone #) _____

HUMAN SERVICE AGENCY
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how protected health inform may be used or disclosed by the Human Service Agency to out