HENRICO AREA MENTAL HEALTH & DEVELOPMENTAL SERVICES

CLIENT ADMISSION

Date: _____

FOR OFFICE USE ONLY
Case Number:_____

Client Status: ( ) Pre-Registered ( ) Registered ( ) Admit

For PIP Program, enter Child ID Code:

*Name of Client: _____
Last Name *Suffix (Jr., Sr. III)* *First Name* *MI*

Date of Birth: _____ Age: _____ *Social Security#: _____

*Gender: ❍ Male ❍ Female If female, are you living with dependent children ages 0-17? ❍ Yes ❍ No ❍ Unknown

*What is your marital status? ❍ Never Married ❍ Married ❍ Separated ❍ Divorced ❍ Widowed

*What is your race?

- ❍ Black/African-American
- ❍ American Indian or Alaska Native & White
- ❍ Asian & White
- ❍ African-American & White
- ❍ American Indian or Alaska Native & African-American
- ❍ American Indian
- ❍ Multi-Racial
- ❍ Alaskan Native
- ❍ Other
- ❍ Native Hawaiian/Pacific Islander
- ❍ Asian
- ❍ White/Caucasian

*Are you of Hispanic origin?

- ❍ Cuban
- ❍ Mexican
- ❍ Puerto Rican
- ❍ Other Hispanic Origin
- ❍ Not of Hispanic Origin
- ❍ Hispanic Specific Origin not identified

What is your preferred language? ❍ English ❍ Other:_____

If custody/visitation order, name(s) of child (ren):_____

_____

Street Address: _____ Apartment Number: _____

City:_____ State:_____ Zip: _____

*In what type of residence do you live (current location)?

- ❍ Boarding Home
- ❍ Community Residential (group home)
- ❍ Foster Home/Family Sponsor
- ❍ Homeless/Homeless Shelter
- ❍ Hospital
- ❍ Licensed Adult Care Residence (ACR)
- ❍ Local Jail or Detention
- ❍ Nursing Home/Physical Rehabilitation
- ❍ Other
- ❍ Other Institutional Setting
- ❍ **Private Residence/School Dormitory**
- ❍ Residential Treatment/Alcohol & Drug Rehabilitation
- ❍ Shelter
- ❍ State Correctional Facility

*In what county do you currently live? If you reside in a group home or state facility, what county did you live in previously? (If homeless, check Henrico County).

- ❍ Charles City County
- ❍ Chesterfield County
- ❍ Goochland County
- ❍ Hanover County
- ❍ **Henrico County**
- ❍ New Kent County
- ❍ Powhatan County
- ❍ Richmond City
- ❍ Other _____

Phone number where we may contact you: *(If you do not wish to be contacted, leave blank)* (___)_____

Work phone: (___)_____ Ext:_____ Other phone (pager, cell, etc.) : (___)_____

HENRICO AREA MENTAL HEALTH & DEVELOPMENTAL SERVICES

CLIENT ADMISSION

Client Name: _____ **Case #:** _____
Last First MI

Primary Emergency Contact Person:

_____ _____ _____
Last Name First Name Middle Initial

Relationship to you: _____

Street Address: _____ Apartment Number: _____

City: _____ State: _____ Zip: _____

Home phone: (___) _____ Work phone: (___) _____ Ext: _____ Other phone: (___) _____

Secondary Emergency Contact Person:

_____ _____
Last Name First Name

Street Address: _____ Apartment Number: _____

City: _____ State: _____ Zip: _____

Home phone: (___) _____ Work phone: (___) _____ Ext: _____ Other phone: (___) _____

May we send correspondence to the following addresses during and/or after services?

Address of Client ❍ Yes ❍ No

Address of Primary Emergency Contact ❍ Yes ❍ No

Address of Secondary Emergency Contact ❍ Yes ❍ No

Legal Guardian

*Legal (Guardian) Status:

- ❍ No Legal Guardian\ <18 w parent
- ❍ <18 has Court Ordered Guardian
- ❍ Authorized Rep. Court Ordered
- ❍ Eighteen +, has legal guardian
- ❍ Protective Payee

If there is a Guardian, complete:

Name of Legal Guardian: _____
Last Name First Name

Street address: _____ Apartment Number: _____

City: _____ State: _____ Zip: _____

Home phone: (___) _____ Work phone: (___) _____ Ext: _____

* Are you a minor? ❍ YES ❍ NO If yes, with whom do you live?

_____ _____ _____
Last Name **First Name** *Relationship to you

CLIENT ADMISSION

Client Name: _____ **Case #:** _____
Last First MI

If you are a minor, please provide parents/caregivers names:

_____ _____ _____
Last Name of **Mother** First Name Middle Initial

_____ _____ _____
Last Name of **Father** First Name Middle Initial

_____ _____ _____ _____
Last Name of **Other Caregiver** **First Name** Middle Initial *Relationship to you

*How many prior treatment episodes have you received in any drug/alcohol treatment programs? _____
(Enter zero, if this is the first treatment or you have never been in a drug/alcohol treatment program.)

Employment and Education Information:

*Current employment status:

- ❍ Disabled: Unable to Work
- ❍ Employment Program
- ❍ Full-time (>35 hours per week)
- ❍ Homemaker
- ❍ Institution or Jail
- ❍ Not in Labor Force
- ❍ Other (includes unemployed and NOT seeking employment)
- ❍ Part-time (<35 hours per week)
- ❍ Retired
- ❍ Student/Job Training (FT or PT, no paid employment)
- ❍ Unemployed: Looking

*What is the highest grade you completed in school?

- ❍ Never Attended School
- ❍ Nursery, Pre-School, Head Start
- ❍ Kindergarten
- ❍ Grade 1
- ❍ Grade 2
- ❍ Grade 3
- ❍ Grade 4
- ❍ Grade 5
- ❍ Grade 6
- ❍ Grade 7
- ❍ Grade 8
- ❍ Grade 7
- ❍ Grade 8
- ❍ Grade 9
- ❍ Grade 10
- ❍ Grade 11
- ❍ Grade 12
- ❍ Special Ed
- ❍ Vocational only
- ❍ College Undergrad Freshman
- ❍ College Undergrad Sophomore
- ❍ College Undergrad Junior
- ❍ College Undergrad Senior
- ❍ Graduate or Professional Prgm

***School Attendance Status:** If client is 3-17 years old or young adult in special education (age 18-21)
I have attended school at least one day during the past 3 months (Respond YES if on Summer Break) ❍ Yes ❍ No

***Military Status:**

- ❍ Armed Forces – Active Duty
- ❍ Armed Forces - Reserves
- ❍ National Guard – not mobilized
- ❍ Retired Armed Forces/National Guard
- ❍ Discharged Armed Forces/National Guard
- ❍ Dependent Family Member
- ❍ Never been in the Military/not a Military Dependent

If military, discharged or retired what was the year you began? _____ If discharged/retired what was the year you left? _____

General Medical Information:

Preferred Primary Care Physician: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Physician's Phone Number: (___) _____ Fax Number: (_____) _____

Name of Preferred Clinic or Hospital: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Do you have any allergies? ❍ Yes ❍ No ❍ Unknown
If yes, to what medications, foods or environmental conditions?_____

CLIENT ADMISSION

Client Name: _____ ***Case #:*** _____
Last ***First*** ***MI***

I hereby apply for the services of Henrico Area Mental Health & Developmental Services for myself as a Client or for the above named person whom I am legally authorized to represent and to act in his or her behalf.

I understand that use and disclosure of my information is governed as set out in the Privacy Notice that has been provided to me.

I understand that in the event of a medical emergency, qualified medical personnel will be contacted to administer the appropriate medical treatment.

I acknowledge that my records will be destroyed six (6) years after my last treatment, or six (6) years after I reach the age of majority, whichever is greater per the General Schedule 18 for Local Governments of Virginia.

It is recommended, as part of your initial comprehensive assessment, that you provide documentation of a current medical examination. You are asked to arrange this through your physician. If you do not have a physician, you may request help in obtaining one. Even though we encourage this, you have the right to decline and this will not affect the services for which you are eligible.

Do you wish to register to vote?

❍ ***I am registered or not eligible*** ❍ ***Yes*** ❍ ***No***

_____ _____
Signature of Client or Authorized Representative ***Date***

Please Note: ***This form, which includes consent to treatment, must be completed before services can begin. If the legal guardian is unable to attend the initial appointment, he/she may show verification of guardianship and proof of identity to a Notary Public. The Notary Public should complete the section below and notarize (with seal). This notarized form, along with copies of the guardianship papers and proof of identity, may be submitted in person by a substitute custodian or via mail:***

Access
Henrico Mental Health & Developmental Services
10299 Woodman Road
Glen Allen, Virginia 23060

804-727-8515 for questions

CLIENT ADMISSION

Client Name: _____Case #:_____
Last First MI

If applicable: Verification of Guardianship or Authorized Representative: (e.g. court order)

- ☐ **Verification copied for Medical Record**
- ☐ **Identify verified and proof of Identity copied for Medical Record**

Notary Public verification (if Client Admission completed out of office)

Name of Notary Public: (please print) _____Date: _____

_____
Signature of Notary Public

Expiration of Commission: _____

Seal:

Completed by: _____ Staff Code: _____

Keying Staff Code: _____ Date Keyed: _____