Human Supports of Idaho

New Participant Application

HUMAN SUPPORTS OF IDAHO

Participant Information

Name:		Date:	
Home Phone:		Cell Phone:	
Work Phone:		Would you like appointment reminders?	
Sex:	☐ Male ☐ Female ☐ Other: _____	Text: Yes / No	Phone Call: Yes / No
Date of Birth:		SSN:	
Address:			
Email:			
Employer / School Name:	(If you note a school, please add grade.)		
Military Status:	☐ Active Duty ☐ Veteran ☐ Other: _____		

Guardian Information ☐ N/A

Name:		Home Phone:	
Relationship:		Cell Phone:	
Preferred Contact Method:	☐ Home Phone ☐ Mobile Phone ☐ Other: _____	Address:	
Email:			

Emergency Contact

May we coordinate care? ☐ Yes ☐ No ☐ N/A

Name:		Home Phone:	
Relationship:		Cell Phone:	
Preferred Contact Method:	☐ Home Phone ☐ Mobile Phone ☐ Other: _____	Address:	

What services are you interested in receiving?

- ☐ Psychiatric Medication Management
- ☐ Individual Psychotherapy
- ☐ Group Psychotherapy
- ☐ Family Psychotherapy
- ☐ Drug/Alcohol Treatment
- ☐ Peer Support Services
- ☐ Case Management
- ☐ Community-Based Rehabilitation (CBRS)

Chief Complaint, Symptoms, and Stressors:

Describe your symptoms, when they started, how often you have them, what triggers them, what makes them worse, what makes them better, etc…

_____

_____

What are your goals for treatment?

_____

_____

_____

Coordination of Care

To provide you the best care possible, we would like to coordinate care with your current and previous service providers and request your medical records from the following providers/treatment team members (as applicable).

Service Type	Provider Name	Clinic / Agency Name	May we Coordinate Care?
Primary Care Physician:			☐ Yes ☐ No ☐ N/A
Psychiatric Medication Management:			☐ Yes ☐ No ☐ N/A
Pharmacy:			☐ Yes ☐ No ☐ N/A
Mental Health Psychotherapy:			☐ Yes ☐ No ☐ N/A
Mental Health Community Services: (CM, CBRS, PSS)			☐ Yes ☐ No ☐ N/A
Drug/ Alcohol (SUD) Treatment:			☐ Yes ☐ No ☐ N/A
Referral Source:			☐ Yes ☐ No ☐ N/A
Other Current Providers:			☐ Yes ☐ No ☐ N/A

Are you currently on Probation or Parole? ☐ Yes ☐ No		**May We Coordinate Care?**
Probation / Parole Office ☐ Ada County Misdemeanor Probation ☐ Canyon County Misdemeanor Probation ☐ Idaho Department of Corrections ☐ Other: _____	**Probation / Parole Officer Name:**	☐ Yes ☐ No ☐ N/A

Have you been to an inpatient behavioral health treatment center? ☐ Yes ☐ No	**May We Coordinate Care?**
If "Yes", please note where and when. _____	☐ Yes ☐ No ☐ N/A

Mental Health History

Have you been diagnosed with any of these conditions?	Age Symptoms Started	Age You Were Diagnosed
☐ Autism Spectrum Disorder		
☐ Attention Deficit/Hyperactivity Disorder		
☐ Bipolar Disorder		
☐ Borderline Personality Disorder		
☐ Drug or Alcohol Use Disorder		
☐ Eating Disorder		
☐ Generalized Anxiety Disorder		
☐ Major Depressive Disorder		
☐ Obsessive Compulsive Disorder		
☐ Panic Disorder		
☐ Posttraumatic Stress Disorder		
☐ Schioaffective Disorder		
☐ Schizophrenia		
☐ Other:		

Trauma History

Some people are willing to talk about their trauma. Others are not ready to talk about it yet. What is your preference?	☐ I am willing to talk about my trauma. ☐ I am **not** willing to talk about my trauma.

Substance Abuse History

Substance Type	Current Use, w/in last 30 days	History of use, Sober 1-3 Months	History of use, Sober 3-12 months	History of use, Sober more than 1 year	No History of Use / Abuse
Alcohol	☐	☐	☐	☐	☐
Nicotine	☐	☐	☐	☐	☐
Illicit Drugs	☐	☐	☐	☐	☐
Prescription and Over-The-Counter Medications	☐	☐	☐	☐	☐

What is/was your drug(s) of choice?

☐ Alcohol
☐ Cannabis (Marijuana, Pot, Weed, etc.)
☐ Depressants (Downers, Klonopin, Valium, Xanax, etc.)
☐ Hallucinogens (Acid, Shrooms, Peyote, Ecstacy, PCP, etc.)
☐ Inhalants (Solvents, Aerosols, Gases, Nitrites, etc.)
☐ Opiates (Codeine, Heroin, Methadone, Morphine, etc.)
☐ Stimulants (Cocaine, Crack, Crank, Meth, Speed, etc.)
☐ Other: _____

Medical History

Do you have any current or previous medical problems?

☐ Arthritis
☐ Cancer
☐ Chronic Pain
☐ COPD
☐ Diabetes
☐ Epilepsy/Seizures
☐ Heart Disease
☐ Hepatitis
☐ High Blood Pressure
☐ HIV
☐ Lung Disease
☐ Migraines/Reoccurring Headaches
☐ MRSA
☐ Neurological Problems
☐ Sexually Transmitted Disease
☐ Stroke
☐ Thyroid Disease
☐ Other:

ADA Accommodations

☐ Wheelchair Access
☐ Trained Service Animal
☐ Hearing Impaired
☐ Hearing Loss
☐ Vision Impaired
☐ Vision Loss
☐ Walk Assistant Devices
☐ Other: _____

Have you ever experienced a traumatic brain injury? ☐ **Yes** ☐ **No**

If yes, please describe, including how, what, when:

_____

_____

Have you been prescribed any medications?

☐ No, I am not prescribed any medications.
☐ Yes, I am taking all of them
☐ Yes, I am taking some of them
☐ Yes, but I don't take them

Medication List (Please list all of your **current** medications here.)**:**

_____ _____ _____

Previous Medications (Please list all of your **previous** medications here.):

_____ _____ _____

Do you have any drug or food allergies? ☐ **Yes** ☐ **No**

If yes, what are they, and what is the allergic reaction (e.g., rash, breathing difficulties)?