Blair County Client Registration Form **7/01/2020**

Client Last Name ____**First Name**____ **Middle Initial**______________

Birth Name if different from Last Name____Phone #:_____________________________________

Street Address ____City/State Zip Code____

Social Security # ________________________________DOB _________________Age________ Male ____Female____ Ethnicity______________________________________

Marital Status: Unmarried____ Married_____ Divorced_____ Widowed _____ Separated _____ SCHOOL: _________________________________GRADE: _________

Answer All that apply with a check mark: _

Pregnant ____Y______N IDU ____Y______N Overdose Survivor ____Y_____N

Involved with Student Assistance ___Y___N HX/Current MH symptoms ___Y___N Woman with Children __Y___N Veteran ___Y___N

Date of Initial Screening (Date actually spoke to person) __________________________**Date of Assessment** ____________________ **If assessment is not within 7 days, WHY? Please check one**

___No capacity, client chose first available date ___Client choice ____SAP Screening ___Other (specify)_________________________

Preliminary Axis 1 Diagnosis: (Primary-1, Secondary-2, Tertiary-3)

___F10.10 Alcohol Abuse ___F10.20 Alcohol Dependence ___F15.10 Amphetamine Abuse ___F15.20 Amphetamine Dependence ___F16.10 Hallucinogen Abuse

___F16.20 Hallucinogen Dependence ___F18.10 Inhalant Abuse ___F19.20 Inhalant Dependence ___ F11.10 Opioid Abuse ___F11.20 Opioid Dependence

___F12.10 Cannabis Abuse ___F12.20 Cannabis Dependence ___F14.10 Cocaine Abuse ___ F14.20 Cocaine Dependence ___Nicotine Dependence

___F19.20 Polysubstance Dependence ___F13.10 Sedative, Hypnotic, or Anxiolytic Abuse ___ F13.20 Sedative, Hypnotic or Anxiolytic Dependence

___F19.10 Other (or Unknown) Substance Abuse ___F19.20 Other (or Unknown) Substance Dependence

Assessment Results:

____Assessed as needing drug and alcohol treatment ___Assessed as not needing drug and alcohol treatment _______Assessed as needing early intervention services

Level of Care:__________________________ **Number of Units for Assessment (15 minute units):________________________**

Medical Assistance Status:

_____Y________N Client is on Medical Assistance IF NO: ________Application was faxed to CAO on____(provide date)

________Client has private insurance

Medicaid # ________________________________ **________Other, Please Explain____**

Prior assessment within 6 months _____ Yes _____ No Client is incarcerated at time of assessment _____ Yes _____ No

Evaluator’s Name and Agency (Please Print)