PARTNERSHIP FOR HEALTHY AGING IN NIAGARA COUNTY

CLIENT INFORMATION

Name *(Last, First, M.I.)*:	**Sex**: ☐ M ☐ F	**DOB:**
Address:	**Marital status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	**Phone** (H):
City:		**Phone** (M):
State:		**Phone** (O):
Zip:		**SSN:**

Living Situation ☐ Private-Alone ☐ Private-Partner ☐ Private-Other Family ☐ Private-Other ☐ Assisted Living ☐ Long-term Care/Nursing Home ☐ Inpatient ☐ Homeless ☐ Unknown ☐ Other	**If Other**, please specify:
Animals in the home:	**Weapons in the home:**

DEMOGRAPHICS

Race: ☐ African-American ☐ Hispanic ☐ Asian-American ☐ Caucasian ☐ Native American ☐ Bi-Racial ☐ Other:	**Ethnicity: Hispanic/Latino** ☐ Yes ☐ No	**Preferred Language:** ☐ English ☐ Spanish ☐ Other:	**Primary Income:** ☐ Social Security ☐ Pension/Retirement ☐ Disability ☐ Earned Income ☐ Family ☐ Other ☐ Unknown

EMERGENCY CONTACT

Name *(Last, First, M.I.)*:			**Relationship:**
Address:			**Phone** (H):
City:	**Phone** (M):	**Zip:**	**Phone** (M/O):

REFERRAL SOURCE

Person Making Referral:	**Date of Referral:**
Agency:	**Telephone #:**

REASON FOR REFERRAL

Presenting Problem:

MEDICAL HISTORY

Mental Health Diagnosis:	**Initial Onset:**
Substance Abuse:	**Medical Problems:**
PMD – Primary Medical Doctor:	

HISTORY OF PREVIOUS TREATMENT

Inpatient Treatment

Inpatient Setting:	Dates:	Reason:	Outcome:

Copy enclosed/ Faxed to 716-278-8130. Attention: Program Supervisor, Community Psychiatric Support and Treatment

V2.0 updated 9/4/2018

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Outpatient Treatment			
Clinician:	**Dates:**	**Reason:**	**Outcome:**

In the last 6 months, have you had?
- ☐ Psychiatric hospitalizations
- ☐ Medical Hospitalizations
- ☐ ER presentations
- ☐ Incarcerations
- ☐ Other: ______________________________

LINKAGES/SERVICES				
	Telephone:	Ext.		
Agency:			Court System:	
Therapist:			Attorney:	Telephone:
Psychiatrist:			Parole:	
Care Manager:			Probation:	
SNAP: ☐ **Yes** ☐ **No**			Task:	
HEAP: ☐ **Yes** ☐ **No**			Mental Health Court:	
Medicaid: ☐ **Yes** ☐ **No**	Medicaid ID:		SPOA: ☐ **Yes** ☐ **No**	Date Application Completed:
Medicare: ☐ **Yes** ☐ **No**				
SSI/SSDI: ☐ **Yes** ☐ **No**				

Additional Issues to be Addressed:

For Office Use Only: ☐ **ASCM** ☐ **BHCM** ☐ **OACS**