PATHWAYS COUNSELING CENTER, INC.

Mental Health Services
Alcohol/Drug Abuse Services
835 North Locust Street
Ottawa, Ohio 45875

419-523-4300 (Phone)
419-523-6188 (Fax)
800-567-4673 (After Hours Crisis Line)
www.pathwaysputnam.org

PLEASE FILL OUT THIS FORM IN ITS ENTIRETY – If a segment does not pertain to you, please indicate by a N/A.

Demographic Information

Today's Date: Time:

Full Legal Name: _____ Maiden Name: _____
Last First Middle Initial

Physical Address: _____
Street City State Zip Code

Date of Birth: _____ Client Age: _____ Soc. Sec. No.: _____ - _____ - _____

County of Legal Residence: _____

Do you receive mail at this location? Y N
If no, please provide a mailing address:
_____

Legal Gender: ⬭ Male ⬭ Female ⬭ Other
Gender at Birth: ⬭ Male ⬭ Female ⬭ Other
Gender Identity: ⬭ Male ⬭ Female ⬭ Other

Cell Phone No.: (_____) _____

Can we leave message? Y N
Can we send texts? Y N

Email Address: _____

Additional Phone No.: (_____) _____ Home Phone ____ Work Phone ____ Other _____
Describe

Primary Language: _____
Client needs the assistance of an interpreter? Y N

⬭ American Sign Language
⬭ Language: _____

Parent/Guardian/Custodian/POA Name and Address

Name: _____ Relation: _____

Address: _____ Phone No.: (_____) _____

_____ Do they live with you? Y N

Marital Status

_____ Common Law
_____ Divorced
_____ Married/Living Together
_____ Separated
_____ Single/Never Married
_____ Widowed

School Information

____ Student YES NO

Highest grade completed:
_____ Grade_____
_____ High School/GED
_____ Some college
_____ College Graduate
_____ Master's Degree

IEP Program? YES NO

Employment Status

____ Employed
- Full Time _____
- Part-Time _____

_____ Unemployed
_____ Disabled
_____ Retired
_____ Homemaker
_____ Inmate of Jail

Income Source

___ Disability
___ Family/Relative
___ No Income
___ Retirement
___ Unemployment
___Wages

Race and Ethnicity

Race:
___ White
___ Black/African American
___ Native American
___ Asian
___ Native Hawaiian/Other Pacific Islander
___ Alaskan Native

Ethnicity:
___ Puerto Rican
___ Mexican
___ Cuban
___ Other Hispanic
___ Not Hispanic or Latino

Who referred you to this program?

_____

Name and Phone of Primary Care Physician:

_____ _____ _____
Name City State

Phone (_____)_____

EMERGENCY CONTACT Name and Phone Number

Name: _____ Relation: _____

Phone No.: (_____) _____ Can leave voicemail? Y N

Does client live with you? Y N Can text message? Y N

Household Information

Total monthly household income $ _____

We simply ask this question to better serve our clients with their insurance/client fees. If you feel you need assistance, please ask to schedule an appointment with our Financial Advisor.

Number of persons living in the household: _____

Veteran Status

___ Active
___ AWOL
___ Dishonorably Discharged
___ Honorably Discharged
___ Medical Discharge
___ None
___ Retired

Insurance Information I currently have (check all that apply):

_____ Medicaid _____ Private Insurance

_____ Medicare _____ No Insurance

What brought you to seek treatment at Pathways?

_____

_____

Treatment in Lieu: ___ Yes ___ No

Household Members (other than yourself) Child's date of birth or start date of living together

Name: _____ Relationship: _____ Date: _____

Name: _____ Relationship: _____ Date: _____

Name: _____ Relationship: _____ Date: _____

Name: _____ Relationship: _____ Date: _____

Name: _____ Relationship: _____ Date: _____

Name: _____ Relationship: _____ Date: _____

Height and Weight

Height:	If a client is a child, has their height changed considerably in the past year? ___ Yes ___ No If yes, by how much?
Weight:	Has the client's weight changed considerably in the past year? ___ Yes ___ No If yes, how much (plus or minus)?

Current list of medications and dosage including any over-the-counter medications:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Past Outpatient Treatment:

Place: _____ Dates: _____

Place: _____ Dates: _____

Place: _____ Dates: _____

Past Psychiatric Hospitalizations:

Place: _____ Dates: _____

Place: _____ Dates: _____

For Females Only:

Are you currently pregnant? _____ No _____ Yes

If yes, are you receiving pre-natal healthcare? _____ No _____ Yes

Date of your last menstrual period: ____/____/_____

Any significant pregnancy history? _____ No _____ Yes, explain_____

Nutritional Screening

___ No Problems

Eating:
___ More
___ Less
___ Not Eating

Drinking:
___ More
___ Less
___ Takes liquids only

Appetite:
___ Increased
___ Decreased

⬭Nausea ⬭ Vomiting ⬭ Trouble Chewing or Swallowing

Special Diet: Y N Type: _____ Other: _____

Substance Use History and Current Use – please check all that apply

	No Use	Past Use	Now Use		No Use	Past Use	Now Use		No Use	Past Use	Now Use
Alcohol/Beer/Wine				Sleep Medication				Cocaine/Crack			
Marijuana				Tranquilizers				Heroin			
Hashish				Hallucinogens				Pain Medication			
Stimulants				Inhalants				Other:			

Caffeine Use? ___ Yes ___ No What kind? _____ (Coffee, Tea, Pop, etc.) How much? _____ (Bottles/cups per week)

Tobacco Use? ___ Yes ___ No What kind? _____ (Cigarettes, Cigars, Vape, etc.) How much? _____ (Packs, etc. per week.)

Authorization

I authorize Pathways Counseling Center, Inc. to release any/or discuss the following information on my behalf to:

- Financial and billing information to _____ Initial _____
  Name Relationship Client/Guardian/POA
- Appointment dates/times including making and cancelling appointments on my behalf _____ Initial _____
  Name Relationship Client/Guardian/POA

Signature of Acknowledgement – I certify that all information reported in this **entire** document is correct. I agree with the client *Fee of Service Agreement*, the agreement has been fully explained to me, and I give permission for this information to be released to my insurance company and/or outside collection services. This is in order to obtain funding and process claims, if eligible, to cover in-part or fully, the costs of services provided by Pathways Counseling Center, Inc. I also authorize payment of benefits directly to Pathways Counseling Center, Inc. for services rendered. I authorize my healthcare provider and/or any entity authorized by my health care provider, including those using automated dialing systems, automated messages, email, text messaging, or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided.

_____ _____

Client's Signature Date Parent/Legal Guardian/ Custodian/POA Date

Updated 02.10.2022