



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.: _____ - _____ - _____	
WE MUST HAVE THIS NUMBER			
County of Legal Residence: _____	Do you receive mail at this location? Y N		
If no, please provide a mailing address: _____			
Legal Gender: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Other			
Gender at Birth: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Other			
Gender Identity: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> 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: _____	<input type="radio"/> American Sign Language		
Client needs the assistance of an interpreter? Y N	<input type="radio"/> Language: _____		

Client's Parent/Guardian/Custodian/POA Name and Address	
Name: _____	Relation: _____
Address: _____	Phone No.: (_____) _____
_____	Do they live with you? Y N

Client's Marital Status
_____ Common Law
_____ Divorced
_____ Married/Living Together
_____ Separated
_____ Single/Never Married
_____ Widowed

Client's Education Information	Employment Status of Client	Race and Ethnicity
____ Student YES NO Highest grade completed: ____ Grade _____ ____ High School/GED ____ Some college ____ College Graduate ____ Master's Degree IEP Program? YES NO	____ Employed - Full Time ____ - Part-Time ____ ____ Unemployed ____ Disabled ____ Retired ____ Homemaker ____ Student ____ Inmate of Jail	Income Source ____ Disability ____ Family/Relative ____ No Income ____ Retirement ____ Unemployment ____ Wages
Who referred you to this program? _____ _____	Name and Phone of Primary Care Physician: _____ Name _____ City _____ State _____ Phone (_____) _____	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

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 - Putnam County Residents ONLY

Total monthly household income \$ _____

Financial assistance *may* be available for Putnam County resident through grant monies from the ADAMHS Mental Health Board. If you feel you may need assistance, we can schedule an appointment with our Billing Department. You will be required to show proof of income.

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 and provide card at initial appointment):

- 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, by how much?
Weight:	Has the client's weight changed considerably in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much (plus or minus)?

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

Do you hold a Medical Marijuana Card? Yes No

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.

Brief Biosocial Gambling Screen (BBS) Questionnaire

1. During the past 12 months, have you become restless, irritable or anxious when trying to stop/cut down on gambling?
_____No _____Yes
2. During the past 12 months, have you tried to keep your family or friends from knowing how much you gambled?
_____No _____Yes
3. During the past 12 months, did you have such financial trouble, as a result of you gambling, that you had to get help with living expenses from family, friends or welfare?
_____No _____Yes

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 02.27.2023

Please Note: If you are seeking Medication Management, Psychiatric Services and/or received Psychiatric Services in the past - please be sure to bring name, address, phone number and fax number of any/all providers (Doctors, Hospitals, etc.).