

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:	Tim	e:			
Full Legal Name:	First	Middle	Maid	len Name:				
Physical Address:Street				State	Zip Code			
Date of Birth:	Client Age: _			· WE MUST HAVE T	-			
County of Legal Residence:	PFemale Other		mail at this loca	tion? Y	his number N			
Gender at Birth: OMale O	Female Other Female Other							
Cell Phone No.: ()		Can we leave n Can we send te	nessage? Y xts? Y	N N				
Email Address:		Call we send te	XIS ! I	1				
Additional Phone No.: ()		Home Phone	Work Phone	Other	Describe			
Primary Language: OAmerican Sign Language Client needs the assistance of an interpreter? Y N OLanguage:								
Minor Client's Parent/Guardian/Cu	stodian/POA Name and A	Address	C	lient's Marital Sta	atus			
Name:	Relation:			Commo				
Address:       Phone No.: ()       Married/Living Together         Separated								
**Bring Legal Guardianship/Custodian/POA paperwork with you.**       Sophated         Single/Never Married       Single/Never Married								
Client's Education Information	Employment Status of C	<u>Client</u>		Race and Ethnic	<mark>zity</mark>			
Student     YES     NO       Highest grade completed:       Grade	Employed - Full Time - Part-Time Unemployed Disabled Retired Homemaker Student Inmate of Jail	Dis Fam No Ret	ability nily/Relative Income irement employment	Native Ame Asian	vaiian/Other nder			
IEP Program? YES NO Who referred you to this	Name and Phone of Prir	nary Care Physics	ian:	Ethnicity: Puerto Rica	ın			
program?			<u>State</u>	Mexican Cuban				
	Name Phone ()	City	Other Hispanic     Not Hispanic or Latino					

EMERGENCY CONTACT Name and Phone	Number			
Name: I	Relation:			
Phone No.: ()	Can leave voicemail?	Y	Ν	
Does client live with you? Y N	Can text message?	Y	Ν	
Household Information – Putnam County Res	idents ONLY			Veteran Status
Total monthly household income \$				Active AWOL
Financial assistance <i>may</i> be available for Putr from the ADAMHS Mental Health Board of I assistance, we can schedule an appointment w required to show proof of income.	Putnam County. If you feel you n	nay need	ies	<ul> <li> NWOL</li> <li> Dishonorably Discharged</li> <li> Honorably Discharged</li> <li> Medical Discharge</li> <li> None</li> </ul>
Number of persons living in the household:				Retired
			[	
Insurance Information I currently have (cl	neck all that apply and provide ca	ard at init	tial appo	pintment):
Medicaid	Private I	nsurance		
Medicare	No Insur	ance		
What brought you to seek treatment at Pathwa	iys?			
			Freetma	nt in Lieu: Yes No
Household Members (other than yourself)			reatifier	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, ha If yes, by how much?	s their height changed consideral	bly in the	past ye	ar?YesNo
Weight:         Has the client's weight           If yes, how much (plus)	changed considerably in the pas	t year?		Yes No

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Current list of medications and	l dosage in	ncluding ar	iy over-the-coun	nter me	dicat	ions:				
Do you hold a Medical Mariju	ana Card?	OY	es O	No						
Past Outpatient Treatment:		1		110						
Place:				П	ates					
Place:										
Place: Past Psychiatric Hospitalizatio				D	ates:				-	
Place:				П	atee					
Place:				D	ates:					
For Females Only:										
Are you currently pregnant?			No			Yes				
If yes, are you receiv	ing pre-nat	al healthc					Yes			
Date of your last mer				_/						
Any significant pregr	-						Yes, explain			
Nutritional Screening			D							
	ing: More			nking: More			Appetite			
Less Decreased										
	Not Eatin	ig		Takes	nqui	us on	Iy			
🔿 Nause	a	0	Vomiting	(	$\circ$	Frout	ble Chewing or Swallow	ing		
Special Diet: Y N Type: Other:										
L										
Substance Use History and Cu	rrent Use	– please ch	leck all that appl	ly						
	No Past Use Use	Now Use		No Use	Past Use	Now Use		No Use	Past Use	Now Use
Alcohol/Beer/Wine		1 1	ep Medication				Cocaine/Crack			
Marijuana			inquilizers				Heroin Dain Madiantian			├───┤
Hashish Stimulants			llucinogens alants				Pain Medication Other:			
Sumulants			uiuito		1		Guidi.	1	I	
~ ~ ~ ~										
Caffeine Use? Yes Tobacco Use? Yes		What	kind? Coffee, kind? Cigaret	, Tea, Pop,	etc.		How much? How much?	Bottles/	cups per	week

Brief B	iosocial Gambling Screen (BBGS) Q	uestionnaire		
1.	During the past 12 months, have yo	ou become restless, irritat	ble or anxious when tryin	ng to stop/cut down on gambling?
		No	Yes	
2.	During the past 12 months, have yo	ou tried to keep your fami	ly or friends from know	ing how much you gambled?
		No	Yes	
3.	During the past 12 months, did you with living expenses from family, f		ble, as a result of you ga	mbling, that you had to get help
		No	Yes	
Authori	zation			
I author	rize Pathways Counseling Center, Inc	e. to release any/or discus	s the following informat	ion on my behalf to:
•	Financial and billing information to	)		Initial
	-	Name	Relationship	Client/Guardian/POA
٠	Appointment dates/times including			
	making and cancelling appointment	ts		
	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 03.06.2024

## Take Note:

- 1. If you are seeking Medication Management, Psychiatric Services and/or have received Psychiatric Services in the past please be sure to bring individual's name, office name, address, <u>phone number</u> and <u>fax number</u> of any/all providers (Doctors, Hospitals, etc.).
- 2. If you are required to provide periodic compliance reports to a P.O., attorney, agency, case worker, or other individual, etc., you **must** provide Pathways with the proper contact, office, address, <u>phone number</u> and <u>fax</u> <u>number</u>.