



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: _____		

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

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
<input type="checkbox"/> Student YES NO Highest grade completed: <input type="checkbox"/> Grade _____ <input type="checkbox"/> High School/GED <input type="checkbox"/> Some college <input type="checkbox"/> College Graduate <input type="checkbox"/> Master's Degree IEP Program? YES NO	<input type="checkbox"/> Employed - Full Time _____ - Part-Time _____ <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Homemaker <input type="checkbox"/> Student <input type="checkbox"/> Inmate of Jail	Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Alaskan Native Ethnicity: <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Mexican <input type="checkbox"/> Cuban <input type="checkbox"/> Other Hispanic <input type="checkbox"/> Not Hispanic or Latino
Who referred you to this program? _____	Name and Phone of Primary Care Physician: Name _____ City _____ State _____ Phone (_____) _____	

Income Source
<input type="checkbox"/> Disability <input type="checkbox"/> Family/Relative <input type="checkbox"/> No Income <input type="checkbox"/> Retirement <input type="checkbox"/> Unemployment <input type="checkbox"/> Wages

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 Residents through grant monies from the ADAMHS Mental Health Board of Putnam County. 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?

Household Members (other than yourself)

Number of Adults: _____ Children under 18: _____

Name: _____	Relationship: _____	Age: _____
Name: _____	Relationship: _____	Age: _____
Name: _____	Relationship: _____	Age: _____
Name: _____	Relationship: _____	Age: _____
Name: _____	Relationship: _____	Age: _____
Name: _____	Relationship: _____	Age: _____
Name: _____	Relationship: _____	Age: _____

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)?

