Care Horizon Inc. Adult Application/Self-Assessment

Name:____ Social Security Number:______________________
First Middle Initial Last

Address:____ County:_____________________
Street City State Zip Code

Phone Number:____ May we leave a message from our office: YES NO

Email address:____ May we contact you via email? YES NO

Birth date:_______________ Age:_______ Gender: ____Male ____Female Race:_________________

Are you of Hispanic origin: ____YES ____NO If yes, detail:____________ Mother's Maiden Name:_____________________

Method of Communication: ______Verbal/Spoken ____Written _____Use Pictures ____Assistive Technology ____TTY

Primary Language: ____English ____Spanish ____American sign language Other:_________________

Are you an American Citizen _________YES ______NO Other, please detail____________________________________

Marital Status: ____Single ____ Married ____Married but Separated ____Divorced ____Widowed ____Living with Significant Other

Who referred you for services________________________________ Reason for referral: ________________________________

Do you have health insurance: YES NO If yes, provider name:____

Do you receive (check all that apply): ____Medicaid ____Medicare ____VA Benefits ____Link Card ____WIC ____SSDI
____SSI ____TANF ____Energy Assistance ____Subsidized Housing ____Unemployment ____None

Resources: ____AA/NA ____Depression/Grief group ___GROW ____Other (detail)___________________________

Legal Status: Are you your own guardian: YES NO Are you your own payee: YES NO
Please list guardian and/or payee:

__________________________________ _______________ _____________________________
Name Relationship Phone

__________________________________ _______________ _____ ______________________
Street Address City State Zip Code

Do you have any special needs: ____YES ____NO If yes, detail:____

Do you have any urgent or critical medical conditions: _____YES ____NO If yes, detail:___________________________________

Presenting Concern:
What is your main concern at this time and why have you come here today:____

How has this issue caused you problems in your life within the past year? ____

Did you just start having this problem: ____YES ____NO
If no, for how long have you had these problems:____
Do your problems interfere with your daily functioning: ____YES ____NO
Have you ever had thoughts of hurting yourself? ____YES ____NO
Have you ever made a suicide attempt? ____YES ____NO If yes, when:______________________
Do you have CURRENT thoughts of hurting yourself? ____YES ____NO
Have you ever had thoughts of hurting someone else?____YES ____NO
Do you have CURRENT thoughts of hurting someone else? ____YES ____NO
Do you feel you are in danger NOW? ____YES ____NO If yes, please explain:__________________________
Are you involved with a gang? ____YES ____NO
Are you in an elder abuse situation? ____YES ____NO
Are you in any other dangerous situation? ____YES ____NO If yes, please explain:_____________________
Do you have enough food to eat? ____YES ____NO
Do you believe you need medication? ____YES ____NO
Additional thoughts or comments:____
____

Needs/Preferences:
What are your preferences for treatment based on the services we have available (check all that apply):
____Counseling ____Community support ____Crisis assistance ____Case management ____Family therapy/counseling
____Medication monitoring ____Psychiatric ____Group counseling ____Other: ________________________

What do you hope to gain from the services you receive? What is your desired outcome?:
____

Care Horizon Inc. encourages the participation of family or persons in your support system during any phase of your treatment.
Do you wish to have anyone present during your assessment? ___YES ___NO
If yes, who:____

By signing this application, I am consenting to completing an intake interview from which a preliminary determination of mental health services shall be made. I agree to participate in the Intake, Assessment and Treatment process:

____ ____________________
Signature Date

Please complete the attached medication form

FOR CARE HORIZON STAFF USE ONLY:
APPLICATION REVIEWED BY:

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