College of Health and Human Services
Unified Clinics
WESTERN MICHIGAN UNIVERSITY

Behavioral Health Services Client Questionnaire

Name: _____ Date of Birth: _____

Gender: ◯ Male ◯ Female Home Phone: _____

Mobile Phone: _____ Other Phone: _____ ◯ No telephone

Emergency Contact

Name: _____ Relation: _____

Phone Number: _____ Is this contact your legal guardian? ◯ Yes ◯ No

Primary Care Physician

Name: _____ Phone number: _____

Address: _____

Referral Information

I was referred by: _____

Demographic Information

Current Living Arrangement: ◯ Dependent ◯ Homeless ◯ Independent

Current Address: _____

City: _____ State: ____ Zip code: _____ County: _____

Race ◯ Arab American ◯ Asian or Pacific Islander ◯ Black/African American ◯ Hispanic
◯ Multi Racial ◯ Native American/Indian ◯ White/Caucasian ◯ Prefer not to respond

Ethnicity: ◯ Arab/Chaldean ◯ Mexican ◯ Puerto Rican ◯ Other Hispanic ◯ None of these

Primary Language spoken: _____

Marital Status: ◯ Never Married ◯ Married/Cohabitating ◯ Widowed ◯ Separated ◯ Divorced

Military Status: ◯ Yes ◯ No

Education: _____

Currently ◯ In Special Education ◯ In Training Program ◯ Attending Undergraduate/Graduate School ◯ N/A

Employment Status: ◯ Employed full time ◯ Employed part time ◯ Unemployed
◯ Not in competitive labor force ◯ Not applicable

Total Annual Income: _____ Number of Dependents: _____

Correction Information

Correction Status: ◯ No status with corrections system ◯ Paroled from Prison ◯ Probation from Jail
◯ Juvenile Detention Center ◯ Court Supervision ◯ Awaiting Trial ◯ Awaiting Sentencing
◯ Decline to answer

Are you involved with any specialty court (drug, sobriety, veterans, mental health)? ◯Yes ◯No

If yes, which court system: _____ which county:_____

In the past 30 days….

How many times have you been arrested: _____

How many times for possession or sale of drugs/alcohol: _____ for DUI/DWI: _____

In the past 5 years….

How many times have you been arrested: _____

How many times for possession or sale of drugs/alcohol: _____ for DUI/DWI: _____

Treatment History

Have you received any other substance abuse treatment or other counseling services: ◯Yes ◯No

How many times have you tried to get this problem fixed? _____

History of Substance Use

Which substances have you used? Please check all that apply.

Substance	Age of First Use	Frequency	Date Last Used	Initially Prescribed?	Order of preference
◯ Alcohol				◯ Yes ◯ No	
◯ Heroin				◯ Yes ◯ No	
◯ Methadone (Illicit)				◯ Yes ◯ No	
◯ Other Opiates or Synthetics				◯ Yes ◯ No	
◯ Barbiturates				◯ Yes ◯ No	
◯ Other Sedatives or hypnotics				◯ Yes ◯ No	
◯ Other tranquilizers				◯ Yes ◯ No	
◯ Benzodiazepines				◯ Yes ◯ No	
◯ GHB/GBL				◯ Yes ◯ No	
◯ Cocaine				◯ Yes ◯ No	
◯ Crack Cocaine				◯ Yes ◯ No	
◯ Methamphetamines				◯ Yes ◯ No	
◯ Amphetamines				◯ Yes ◯ No	
◯ Methcathinone				◯ Yes ◯ No	
◯ Hallucinogens				◯ Yes ◯ No	
◯ PCP				◯ Yes ◯ No	
◯ Marijuana/Hashish				◯ Yes ◯	

				No	
◯ Ecstasy (MDMA, MDA)				◯ Yes ◯ No	
◯ Ketamine				◯ Yes ◯ No	
◯ Inhalants				◯ Yes ◯ No	
◯ Antidepressants				◯ Yes ◯ No	
◯ Over-the-counter				◯ Yes ◯ No	
◯ Steroids				◯ Yes ◯ No	
◯ Talwin and PBZ				◯ Yes ◯ No	
◯ Other				◯ Yes ◯ No	

Client Signature: _____ Date: _____

Health Conditions Measures

The agency that is funding your treatment, KCMHSAS, is required to gather the following information. We, at USAC, are also interested to help if you are experiencing difficulties in any of the areas listed below. Please read and rate the following:

Hearing

Ability to hear (with hearing appliance normally used)

- ◯ Adequate—No difficulty in normal conversation, social interaction, listening to TV
- ◯ Minimal difficulty—Difficulty in some environments (e.g., when person speaks softly or is more than 6 feet away)
- ◯ Moderate difficulty—Problem hearing normal conversation, requires quiet setting to hear well
- ◯ Severe difficulty—Difficulty in all situations (e.g., speaker has to talk loudly or very slowly; or hearing speech as mumbled)
- ◯ No hearing

Hearing aid used **(HEARAID)** ◯ Yes ◯ No

Vision

Ability to see in adequate light (with glasses or with other visual appliance normally used)

- ◯ Adequate—Sees fine detail, including regular print in newspapers/books or small items in pictures
- ◯ Minimal difficulty—Sees large print, but not regular print in newspapers/books or cannot identify large objects in pictures
- ◯ Moderate difficulty—not able to see newspaper headlines or items in pictures, but can identify objects in the environment
- ◯ Severe difficulty—Difficulty identifying objects, but eyes follow objects, or you see only light, colors, shapes
- ◯ No vision—eyes do not appear to follow objects; absence of sight

Visual appliance **(VISAPP)** ◯ Yes ◯ No

Health Conditions

Pneumonia (2 or more times within past 12 months) – including Aspiration Pneumonia **(PNEUM)**

◯ Never present ◯ History of condition, but not treated for the condition within the past 12 months
◯ Treated for the condition within the past 12 months ◯ Information unavailable

Asthma (ASTHMA)

◯ Never present ◯ History of condition, but not treated for the condition within the past 12 months
◯ Treated for the condition within the past 12 months ◯ Information unavailable

Upper Respiratory Infections (3 or more times within past 12 months) **(RESP)**

- ◯ Never present
- ◯ History of condition, but not treated for the condition within the past 12 months
- ◯ Treated for the condition within the past 12 months
- ◯ Information unavailable

Gastroesophageal Reflux, or GERD (GERD)

- ◯ Never present
- ◯ History of condition, but not treated for the condition within the past 12 months
- ◯ Treated for the condition within the past 12 months
- ◯ Information unavailable

Chronic Bowel Impactions (BOWEL)

- ◯ Never present
- ◯ History of condition, but not treated for the condition within the past 12 months
- ◯ Treated for the condition within the past 12 months
- ◯ Information unavailable

Seizure disorder or Epilepsy (SEIZURE)

- ◯ Never present
- ◯ History of condition, but not treated for the condition within the past 12 months
- ◯ Treated for the condition within the past 12 months and seizure free
- ◯ Treated for the condition within the past 12 months, but still experience occasional seizures (less than one per month)
- ◯ Treated for the condition within the past 12 months, but still experience frequent seizures
- ◯ Information unavailable

Progressive neurological disease, e.g., Alzheimer's (NEURO)

- ◯ Not present
- ◯ Treated for the condition within the past 12 months
- ◯ Information unavailable

Diabetes (DIABETES)

- ◯ Never present
- ◯ History of condition, but not treated for the condition within the past 12 months
- ◯ Treated for the condition within the past 12 months
- ◯ Information unavailable

Hypertension (HYPERTEN)

- ◯ Never present
- ◯ History of condition, but not treated for the condition within the past 12 months
- ◯ Treated for condition within the past 12 months and blood pressure is stable
- ◯ Treated for condition within the past 12 months, but blood pressure remains high or unstable
- ◯ Information is unavailable

Obesity (OBESITY)

- ◯ Not present
- ◯ Medical diagnosis of obesity or 30 pounds overweight

_____ _____

Name **Date**

BEHAVIORAL HEALTH SERVICES

KCMHSAS – Communicable Diseases Screening Tool

IMPORTANT: This questionnaire was designed to help our staff better serve you and care of your needs. It asks very private and intimate questions. Your answers will be kept in strict confidentiality.

PART I – Questions Related to Exposure to TB

1. Have you ever been told by a physician or other health care provider that you have had a positive test for TB or been told that you have TB? YES ☐ NO ☐

   If "YES", do you remember when this was? _____

   Did you follow up with a physician or health care provider? YES ☐ NO ☐*
   (*NOTE to staff: If "NO", refer for TB screening/follow-up)

2. Have you ever received treatment for TB disease? YES ☐ NO ☐
   If "YES", when? _____ For how long? _____

3. Have you ever lived with someone or spent time with someone who has had TB? YES ☐ NO ☐

4. Have you ever lived on the street or in a shelter or been in jail, a psychiatric hospital or in other close quarters with people you did not know well? YES ☐ NO ☐
   If "Yes", please give a brief description of it: _____
   _____
   _____

5. Are you a veteran/active military who has been stationed in Afghanistan within the past five years (or do you live with someone who is and has been)? YES ☐ NO ☐

6. Within the last 30 days, have you had or have you lived with anyone who has had any of the following symptoms for more than two weeks?

a. Fever	YES ☐	NO ☐
b. Night sweats	YES ☐	NO ☐
c. Chills	YES ☐	NO ☐
d. Lingering cough that produces mucus (phlegm)	YES ☐	NO ☐
e. Coughing up blood	YES ☐	NO ☐
f. Shortness of breath	YES ☐	NO ☐
g. Lumps or swollen glands in the neck or under the arm	YES ☐	NO ☐
h. Loss of appetite	YES ☐	NO ☐
i. Sudden or significant weight loss	YES ☐	NO ☐
j. Excessive or lingering fatigue	YES ☐	NO ☐

PART II – Questions Related to Exposure to HIV, Hepatitis (A, B, or C) and Sexually Transmitted Diseases

NOTE: If you have tested positive for HIV/AIDS or Hepatitis C in the past and need a referral for services for either of these infections, please let our staff know.

NOTE to Staff: If "YES", refer to local HIV and/or HCV

1. Have you ever shared needles or injecting "works" with other individuals, including your spouse or significant other, even once, or a long time ago? YES ☐ NO ☐

2. Have you had any needle stick injury? YES ☐ NO ☐

3. Do you have any body art such as tattoos or body piercing? YES ☐ NO ☐

4. Have you ever experienced other forms of blood-to-blood or body fluid contact including:
   - ☐ Blood transfusion or organ transplant before July 1992
   - ☐ Received blood clotting factor made before 1992
   - ☐ Been on hemodialysis
   - ☐ Had occupation exposure to blood in a medical care or public safety setting

5. Have you ever been told you have elevated liver enzymes or liver disease? YES ☐ NO ☐

6. Have you used cocaine with a shared straw or dollar bill? YES ☐ NO ☐

7. Have you had any mucosal exposure to bodily fluids such as splashing of blood into the eye or into an open wound/skin cut? YES ☐ NO ☐

8. Have you, or anyone you've had sex with, had any of the following symptoms within the last 30 days? (check all that apply)

   For men and women:
   - ☐ Sore or ulcer on the penis/vagina ("down there")
   - ☐ Rash or spots, especially on your palms or on the soles of your feet
   - ☐ Burning when you urinate

   For women only:
   - ☐ A vaginal discharge that is different from what you usually have
   - ☐ Pain when you have vaginal sex
   - ☐ Pain in your lower abdomen

   For men only:
   - ☐ Unusual discharge from the penis (example: pus)

9. Have you, or someone you've had sex with, experienced the following:

- [ ] Forced sex
- [ ] Homelessness
- [ ] Mental health issues
- [ ] Migrant work
- [ ] More than one sex partner in six months
- [ ] Exchanged sex for drugs or money
- [ ] Incarceration for a period longer than two days

10. Have you had sexual experiences with:

- [ ] Someone who injects drugs
- [ ] An anonymous partner (someone you do not know)
- [ ] (Men Only): Other men
- [ ] (Women Only): A man who has had sex with a man
- [ ] Someone who has had a recent sexually transmitted disease (STD)
- [ ] Someone living with HIV/AIDS
- [ ] A person against my will
- [ ] Someone unaware of their HIV status
- [ ] Someone whose drug and sexual history is unknown to you

PART III – To be Completed by Our Agency Staff Only

This Consumer:

- [ ] May be pregnant

Is at risk for the following (check as appropriate):

- [ ] HIV/AIDS
- [ ] STD/STIs
- [ ] Hepatitis B
- [ ] Hepatitis C (primarily IDU)
- [ ] TB
- [ ] None

If at risk, by staff signature below you are confirming that you have identified applicable health referral resources for the consumer based on high risk behavior identified above, and have given the information to them. Individuals with Hepatitis C should be referred for vaccination with Hepatitis A and evaluation for possible vaccination with Hepatitis B, if they have not already been vaccinated against these diseases.

- [ ] No additional referrals needed based on risk and/or client is already receiving needed services for communicable diseases (check if appropriate).

Consumer indicates that she/he (circle one):

- [ ] plans to follow-up on these referrals
- [ ] does not plan to follow-up on these referrals

Comments:

_____

_____

_____

_____ _____

Staff Signature Date

To be read and signed by consumer:

If I have identified any behavior that would indicate risk for communicable disease, I have been given information on where I can receive additional information or testing.

_____ _____

Consumer Signature Date Witness Date

Thank you for completing this questionnaire!