

eXclusive Services

11134 Luscheck Drive
Cincinnati, OH 45241
Office: (513) 827-9273
Fax: (513) 818-9960
treatment@xservices.org

NEW CLIENT REGISTRATION FORM
(Please make sure all information is complete and correct)

Identifying & Demographic Information

(please fill out completely)

Date of Phone Interview: ___/___/___ Interview Facilitator: _____ Date of Office Intake: ___/___/___

Client's Name (First, M., Last): _____

Address: _____ City: _____ State: _____ Zip Code: _____

County: _____ Referring agency or person: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Age: _____ Date of Birth: ___/___/___ SS#: _____ - _____ - _____ Marital Status: _____

Student: Yes No Gender: M F Other Ethnicity: _____ Race: _____

Do you currently have stable housing? Yes No *If no, are you interested in stable housing resources?* Yes No

Are you a United States Military Veteran? Yes No

Emergency Contact Information

(please fill out completely)

Parent/Guardian/Custodian if minor (include name and address): _____

Relationship to client: _____ Parent/Guardian/Custodian Phone: (_____) _____ - _____

Emergency Contact (include name and address): _____

Relationship to client: _____ Emergency Contact Phone: (_____) _____ - _____

Do you have an Advance Directive? (eg. Living Will) Yes No

General Information

(please fill out completely)

Have you previously been a client/patient of eXclusive Services? Yes No

If yes, which program(s)? _____ *Did you complete the program(s)?* Yes No

If yes, when? ___/___/___ *If no, why were you unable to complete the program?* _____

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Substance Abuse/Addiction History

(please answer honestly and to the best of your ability)

What is/are your Drug(s) of Choice? _____

How long have you used? _____ When was your last use? ____/____/____

What was the amount that you used (dollar amount or another quantifying amount eg. grams, milligrams, etc.)? _____

Are you currently experiencing any issues with gambling? Yes No

Are you currently pregnant (female only)? Yes No *If yes, how far along are you?* _____

Have you had an *Alcohol and other Drug Assessment* in the last 90 days? Yes No

If yes, where? _____

If yes, when was your assessment conducted? ____/____/____

If yes, what was your diagnosis/diagnoses? _____

Have you been enrolled in *Alcohol and other Drug treatment* in the last 90 days? Yes No

If yes, where? _____

If yes, what program(s) were you enrolled in? _____

If yes, what period of time were you enrolled? ____/____/____ through ____/____/____

Did you complete the program? Yes No

If yes, when did you complete the program? _____

If no, please explain why you did not complete the program: _____

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Mental Health History

(please answer honestly and to the best of your ability)

Have you had an *Mental Health Assessment* in the last 90 days? Yes No

If yes, where? _____

If yes, when was your assessment conducted? ____/____/____

If yes, what was your diagnosis/diagnoses? _____

Have you been enrolled in *Mental Health treatment* in the last 90 days? Yes No

If yes, where? _____

If yes, what program(s) were you enrolled in? _____

If yes, what period of time were you enrolled? ____/____/____ through ____/____/____

Did you complete the program (if applicable)? Yes No N/A

If yes, when did you complete the program? _____

If no, please explain why you did not complete the program: _____

Are you currently under a *Psychiatrist's care*? Yes No

If yes, when was your last visit? ____/____/____

If yes, what is your *Psychiatrist's name or the practice name*? _____

If yes, what is your *Psychiatrist's contact information*? _____

Are you currently being *prescribed medication* by your psychiatrist? Yes No

If yes, please *list your prescribed medications*: _____

Please note: *It is a requirement of this agency that if you have previously been rendered a Mental Health diagnosis and are not currently enrolled with a Mental Health provider, you must schedule an appointment with this agency's Mental Health provider for a general wellness check.*

Please note: *It is a requirement of this agency that if you are currently receiving medications for your mental health, but are not currently enrolled with a Mental Health provider, you must schedule an appointment with this agency's Mental Health provider for a general wellness check.*

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Primary Care History

(please answer honestly and to the best of your ability)

Do you currently have a *Primary Care Physician*? Yes No

If yes, when was your last visit? ____/____/____

If yes, what is your *Primary Care Physician's name or the practice name*? _____

If yes, what is your *Primary Care Physician's contact information*? _____

Are you currently being *prescribed medications* by your PCP? Yes No

If yes, please *list your prescribed medications*: _____

If yes, for which illness and/or issues are you currently seeing your physician? _____

If no, are you interested in obtaining a primary care provider? Yes No

Please note: *It is a requirement of this agency that if you have not had an appointment with your current Primary Care Physician in the last 12 months, you must schedule an appointment with this agency's PCP for a general wellness check.*

Please note: *It is a requirement of this agency that if you do not currently have a Primary Care Physician, you must schedule an appointment with this agency's PCP for a general wellness check.*

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Employment Verification

42 CFR and HIPPA Confidentiality Regulations prevents eXclusive Services from contacting your employer without consent. All clients are required to provide eXclusive Services information pertaining to your current employment to better assist you and your counselor in developing a treatment plan that will be advantageous to both your treatment and this agency's requirements.

Are you currently employed? Yes No If yes, please provide the following information:

Company Name: _____

Address: _____

Legal Occurrences

(please answer honestly and to the best of your ability)

Are you currently experiencing any legal issues? Yes No If yes, please explain below:

Do you have a Probation/Parole officer? Yes No

If yes, what is your Probation/Parole Officer's name? _____

If yes, which county(ies) does your Probation/Parole Officer represent? _____

If yes, what is your Probation/Parole Officer's contact information? _____

Are you involved with Child Protective Services? Yes No If yes, please explain below:

If yes, what is your CPS Case Worker's name? _____

If yes, which county(ies) does your CPS Case Worker represent? _____

If yes, what is your CPS Case Worker's contact information? _____

What Service(s) / Program(s) are you interested in?

[eg. Assessment, Counseling, Medication Assisted Treatment, Mental Health, Primary Care, etc.]

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Insurance Information

Primary Insurance Company: _____

Payer Name(s): _____ Member ID or Policy No.: _____

MMIS No. (if applicable): _____ Group No.: _____

Secondary Insurance Company (if applicable): _____

Payer Name(s): _____ Member ID or Policy No.: _____

MMIS No. (if applicable): _____ Group No.: _____

Is an Employee Assistance Program involved? Yes No

If yes, please explain: _____

For Office Use Only:

Did client provide contact information for facility(ies) regarding previous treatment efforts (if applicable)? Yes No

If no, please explain: _____

If yes, please provide the facility name(s) and contact information below:

Agency Name: _____ Contact Information: _____

Agency Name: _____ Contact Information: _____

Agency Name: _____ Contact Information: _____

If yes, will client provide a *Release of Information* from this/these facility(ies)? Yes No

If no, please explain: _____

If yes, what information will be requested (please mark each that will apply):

Assessment Treatment Plan Progress Notes UDS/Lab Results Medication List

Other: _____