eXclusive Services
11134 Luschek 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? _________________________________

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, w*ill 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: ____