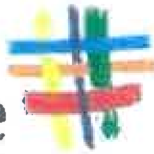

childguidance
&familysolutions

CENTRAL OFFICE
18 N. Forge Street
Akron, OH 44304-1317
Phone: 330-762-0591
Fax: 330-762-2242
www.cgfs.org

Thank you for your interest in receiving services here at Child Guidance & Family Solutions (CG&FS). We look forward to working with your family. Below is some additional information about your first appointment that we hope you will find helpful:

- The initial appointment will be for the identified adult client. If you are cared for by a guardian, then you will need to bring your court approved guardianship papers so we can make a copy for our records.
- Please bring with you a copy of the completed client questionnaire to the initial appointment. If you forget or are unable to complete it, we will ask you to stay after your appointment to complete the client questionnaire. This information is very helpful to the therapist you will be seeing.
- The initial appointment will last approximately one hour with the CG&FS therapist. The therapist has reserved this appointment time for you. If you need to cancel, please contact our Admissions Department as soon as possible to discuss rescheduling.
- A financial interview will be conducted by our Medical Records Staff before you meet with the therapist. At that interview, we ask that you bring all insurance cards you have to be copied for our records and documentation of household income for sliding scale fee (see below). We accept Ohio Medicaid and multiple commercial insurance plans. If you have questions about your benefits you can contact your insurance company or our billing department (330-794-4254).

In addition to accepting Ohio Medicaid and commercial insurance, pending your eligibility (requirements below), CG&FS can also offer Summit County residents the ADM Board sliding scale fee. In order to establish a sliding scale fee CG&FS must verify your residency in Summit County by using both the address and the client's social security number. The provider must also be contracted with the commercial insurance plan or they will need to be referred to a network provider. Proof of household income must also be provided for verification. The household income (guidelines as outlined by the Summit County ADM Board) is based on the income of either the individual or family including; gross salary/wages (pay stubs, tax forms 1040, Schedule C), Social Security benefits, dividends, interest, pensions, annuities, unemployment compensation, worker's compensation, alimony, child support, strike benefits, trusts, inheritance, SSI or other public assistance programs. The determination of whether an asset is a countable resource shall be based upon requirements applicable to Medicaid eligibility.

For additional information, please visit the CG&FS agency website at www.cgfs.org or call our Admissions Department at 330-762-0591 if you have any questions and we will be happy to assist you.

childguidance
&familysolutions

Client #______________

ADULT CLIENT QUESTIONNAIRE

Welcome. Thank you for choosing Child Guidance & Family Solutions.
Please complete all of the information below.
It is valuable and needed to better understand you
as well as to meet the standards of our accrediting bodies.

CLIENT INFORMATION

Last Name______________________________ First Name______________________ Middle Initial______

Date of Birth:__________________ Sex: ☐ F ☐ M Social Security Number: ______________________

Home Address:______________________________________ City:____________ Zip (+4):__________

County of Residence: ________________ Highest Level of Education Completed:______________________

Home Phone: ____________________ Work Phone: ____________________ Cell Phone:____________________

Preferred Method of Contact: ☐ Home ☐ Work ☐ Cell May we leave a message? ☐ Yes ☐ No

What is your current height and weight? Height ________ Weight__________ Do you smoke?: ☐ Yes ☐ No

Marital Status: ☐ Divorced (date of divorce)__________ ☐ Unmarried couple (how long?)____________

☐ Married (date of current marriage)____________ ☐ Separated ☐ Never Married ☐ Widowed

Employment Status: ☐ Full-time ☐ Part-time ☐ Disabled ☐ Homemaker ☐ In the Armed Forces

☐ Not in Labor Force ☐ Retired ☐ Student

Race: ☐ Alaskan Native ☐ Native American ☐ Asian ☐ Black/African American

☐ Pacific Islander/Hawaiian ☐ Two or more races ☐ Unknown ☐ White/ Caucasian

Ethnic Origin: ☐ Not of Hispanic Origin ☐ Cuban ☐ Mexican /Mexican-American ☐ Other Hispanic

☐ Puerto Rican ☐ Unknown

Employer:____ Occupation:__________________

MILITARY/VETERAN STATUS (if applicable):____

EMERGENCY CONTACTS

Who should we contact in case of emergency person? Contact person needs to be local.

Name	Relationship to You	Primary Phone #	Secondary Phone #

I give permission to contact the above people in case of emergency.

____ ____________________

Signature **Date**

rev. 12/2017

childguidance
&familysolutions

Client #________________

Who referred you to Child Guidance & Family Solutions?

- ☐ School Please list: ______________________ ☐ Employer/EAP Provider ☐ Insurance Panel Provider List
- ☐ Primary Care MD/DO ☐ Private Mental Health Professional ☐ Mental Health Agency
- ☐ Akron Children's Hospital ☐ Akron Children's Hospital PHP/IOP/PIRC ☐ Hospital
- ☐ Family/Relative ☐ Friend ☐ Other family member is/was a client ☐ Was a client here before
- ☐ Summit County Children's Services ☐ Out of county Children's Services ☐ Court ☐ Police/Diversion
- ☐ Child Guidance & Family Solutions Employee ☐ Other______________________

INCOME SOURCES (check all that apply):

- ☐ Wages ☐ Family ☐ Alimony ☐ Child Support ☐ Savings ☐ Disability Insurance ☐ Unemployment
- ☐ Retirement ☐ Social Security ☐ Food Stamps ☐ OWF ☐ SSI ☐ None
- ☐ Other______________________

PRIMARY INSURANCE INFORMATION: Bring Copy of Current Card(s)

Insurance Company: ______________________

ID#______________________ Group/Contract # ______________________

Policy Holder Name: ______________________ Policy Holder Birthdate: ______________________

Policy Holder Address (if different from clients): ______________________

City: ______________ State:________ Zip:________

Policy Holder Employer:______________________ Policy Holder SSN#: ______________

Relationship to the client: ☐ Self ☐ Spouse/Partner ☐ Mother ☐ Father ☐ Other: ______________

SECONDARY INSURANCE INFORMATION: Bring Copy of Current Card(s)

Insurance Company: ______________________

ID#______________________ Group/Contract # ______________________

Policy Holder Name: ______________________ Policy Holder Birthdate: ______________________

Policy Holder Address (if different from clients): ______________________

City: ______________ State:________ Zip:________

Policy Holder Employer:______________________ Policy Holder SSN#: ______________

Relationship to the Client: ☐ Self ☐ Spouse/Partner ☐ Mother ☐ Father ☐ Other: ______________

Are there any members of your household currently receiving services from Child Guidance & Family Solutions? ☐ Yes ☐ No

childguidance &familysolutions

Client #________________

SPOUSE/PARTNER INFORMATION (if applicable)

Last Name________________ First Name________________ Middle Initial______

Date of Birth________________ Sex: ❑ F ❑ M Highest Level of Education Completed:________________

Employment Status: ❑ Full-time ❑ Part-time ❑ Disabled ❑ Homemaker ❑ In the Armed Forces

❑ Not in Labor Force ❑ Retired ❑ Student

PREVIOUS RELATIONSHIP/MARITAL INFORMATION (if applicable)

Previous Marriage(s)

	List Name(s)	Date(s) Married	Date(s) Terminated	How Terminated
Wife				
Husband				
Partner				

CHILDREN:

Full Name	Living in your home (Y/N)	Birthdate	Sex	School/Employer

OTHERS IN THE HOME:

Full Name	Relationship

CURRENT LIVING ARRANGEMENTS:

❑ Homeowner ❑ Rent ❑ Friend's Home ❑ Relative's Home

❑ Supervised Group Home ❑ Crisis Residential ❑ Supervised Apartment ❑ Boarding Home

❑ Foster Adult Care ❑ Homeless ❑ Other________________

Are you experiencing any stress? ☐ No ☐ Yes, what type of stress and how often? ____________

____

____

Have you ever had thoughts about hurting yourself? ☐ No ☐ Yes, when/how often? ____________

____

____

Do you feel like hurting yourself now? ☐ No ☐ Yes, when/how often? ____________

____

____

Has violence ever been a concern in past or present relationships? ☐ No ☐ Yes, please explain ____________

____

____

____

____

WHAT DO YOU HOPE TO GET FROM SERVICES HERE? ____________

____

____

____

____

NUTRITIONAL INFORMATION

Do you eat balanced meals? ☐ No ☐ Yes **Do you skip meals?** ☐ No ☐ Yes

Have you experienced a change in appetite lasting 3 days or more? ☐ No ☐ Yes, an **INCREASE** in appetite

☐ Yes, a **DECREASE** in appetite

Have you experienced any unplanned or unusual weight loss or weight gain *(5 pounds in 1 month or 10 pounds in 6 months)*?

☐ No ☐ Yes, weight **LOSS**, how much? ________ ☐ Yes, weight **GAIN**, how much? ________

Do you have food cravings? ☐ No ☐ Yes, what? ____________

If you use tobacco? ☐ NA How much? ____________

Do you use alcohol *(beer, wine, mixed drinks)*? ☐ No ☐ Yes, what do you drink, how often, how much? ____________

____

____

For office use only:

BMI = ________

childguidance &familysolutions

Client Name & Number ______________________________

MEDICAL HISTORY

In the past, have you or anyone in your current household received counseling or psychotherapy from a counselor, psychologist, or social worker? ☐ No ☐ Yes (complete the following)

Who was treated	Year	Problem	Therapist/Agency Name	Medication

Psychiatrist Name and Phone (if applicable): ______________________________

Psychiatrist Location (if applicable): ______________________________

Primary Care Physician and Phone Number: ______________________________

Primary Care Physician Location: ______________________________

PHYSICAL EXAM HISTORY

List information about the last physical exam for yourself.

Date(s)	Physician's Name	Physician's Address	Recommendations made	Medication

List any medical problems that you are presently being treated for:

Date(s)	Hospital/facility	Physician Address	Recommendations made	Medication

List any Hospitalization/residential treatment history:

Date(s)	Hospital/facility	Recommendations made	Medication

Are you experiencing any physical pain? ☐ No ☐ Yes, where and what are you doing to manage it? ______________________________

____

____

Is a referral to physician necessary? ☐ No ☐ Yes, ______________________________

childguidance &familysolutions

Client Name & Number ____________________

Have you had or currently have, any of the following problems?

	Rheumatic Fever
	Eye Trouble
	Tuberculosis
	Thyroid Problems
	Diabetes
	Convulsions
	Asthma
	Kidney Disease
	Ear/Nose Problems
	Dental Problems
	Shortness of Breath
	Arthritis
	Delirium Tremors
	Nervous Problem
	Liver Problems
	Other (explain)

	Frequent Headaches
	Heart Trouble
	Jaundice
	Painful Urination
	Depression
	Anxiety Attacks
	Tumor, Cancer
	Growth, Cyst
	Chest Pain
	Hallucination
	Rheumatism
	Pancreatitis
	Hepatitis
	High Blood Pressure
	Allergies (list)

List any current medications. Include over the counter, herbals, and vitamins.____________________

____

____

____

I agree that the above is true and correct to the best of my knowledge.

____________________ ____________________
Person(s) completing questionnaire Date

OFFICE USE ONLY – PLEASE LEAVE BLANK

Physical health and nutrition information reviewed by:
❑ Psychiatrist ❑ Other Physician ❑Nurse

____
Signature ____________________ Date

Recommendation for referral to physical health services:
❑ Yes ❑ No

If yes, date letter sent to client and by whom:

____
Name ____________________

Recommendation for referral for nutritional assessment:
❑ Yes ❑ No

If yes, date letter sent to client and by whom:

____
Name ____________________ Date

childguidance
&familysolutions

Client Name and #: ______________________ Date: ______________

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ + ______ + ______ + ______

=Total Score: ______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

childguidance
&familysolutions

Client Name and #: ______________________ Date: ____________

GAD-7

Over the **last 2 weeks**, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)