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| **DATOS PERSONALES DEL CLIENTE** | | | | | | | | | | | | | | | | | | | | | | |
| **CLIENT INFORMATION FORM (SPANISH)** | | | | | | | | | | | | | | | | | | | | | | |
| **DIVISION:**  AOABH  BHCOE  CYBH | | | | | | | | | | | | | **FACILITY:** | | | | | | | | | |
| **Date:** | | | | | | | | | | | **INTAKE**  **UPDATE**  **SAME DAY REG / DC** | | | | | | | | | | | |
| **(Por favor use letra de imprenta y llene el formulario lo mejor posible)** | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Persona que completa el formulario:**  Person Filling Out Form: | | | | | | | | | | | | Cliente  Client | | | | Padre/Madre  Parent | | | | | | Tutor  Guardian |
|  | | | | | | | | | | | | Médico  Clinician | | | | Otro        Other | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | |  |  | | | | | | | | |  |  | | | |
| Apellido  Last Name | | | | | | | |  | Primer Nombre  First Name | | | | | | | | |  | Segundo Nombre  Middle Name | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  |  | | | | | | | | |  |  | | | | | | | |
| Nombre Preferido  Name You Prefer to Be Called | | | |  | Nombre de Soltera  Maiden Name | | | | | | | | |  | Apellido al Nacer  Igual que el de más arriba  Birth Name Same as Above | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **¿Ud. o su familia inmediata, han servido en el ejército de los EE. UU?**  Have you or an immediate family member ever served in the US Military? | | | | | | | | | | | | | | | | | | | | | | |
| *Definición de Familia Inmediata: Padres, Hermanos, Hijos (biológico / adoptivo / hijastro)* | | | | | | | | | | | | | | | | | | | | | | |
| Ud. Solo  Self Only | | | Familia Inmediata  Immediate Family | | | | | | | | | | | | | | Ud. y un miembro de su familia  Both Self & Immediate Family | | | | | |
| Nadie  None | | | Prefiere No Contestar  Decline to State | | | | | | | | | | | | | | Desconocido  Unknown | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ | | | | | |  | | | | \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ | | | | | | | | | | |  | |
|  | | | |  | |
| Fecha de Nacimiento  Date of Birth | | | | | |  | | | | Número de Seguro Social  Social Security Number | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Género**  Gender | | | | | | | | | | | | | | | | | | | | | | |
| Fem  Female | Masc  Male | | | | | | Transsexual: | | | | | | Fem. a Masc.  Female to Male | | | | | | | Masc. a Fem  Male to Female | | |
| Desconocido  Unknown | Prefiere No Contestar  Decline to State | | | | | | | | | | | | Otro  Other | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Orientación Sexual**  Sexual Orientation | | | | | | | | | | | | | | | | | | | | | | |
| Bisexual  Bisexual | | Gay  Gay | | | | | | | | | | | Heterosexual  Heterosexual | | | | | | | Lesbiana  Lesbian | | |
| Dudoso  Questioning | | Prefiere No Contestar  Decline to State | | | | | | | | | | | Otro  Other | | | | | | | | | |

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| **Pronombres de género preferido**  Preferred Gender Pronouns | | | | | | | |
| él, él, de él  He / Him / His | ella, ella, de ella  She / Her / Hers | | | | | ellos/as, ellos/as, de ellos/as  They / Them / Theirs | |
| Prefiere No Contestar  Decline to State | Otro  Other | | | | | | |
|  | | | | | | | |
| **¿Ha tenido otros nombres diferentes del actual?**  Have You Gone by Other Names in the Past? | | | | | No  No | | Si  Yes |
|  | | | | | | | |
|  | |  | |  | | | | |
| Nombre anterior #1 ( Apellido, Nombres)  Previous Name #1 (Last, First, MI) | |  | Nombre anterior #2 (Apellido, Nombres)  Previous Name #2 (Last, First, MI) | | | | |

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| **DEMOGRAFIA DEL CLIENTE** | | | | | | *CLIENT DEMOGRAPHICS* | | | | | | | | | | | | | | | | | | | | | |
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| Número de la Licencia de Conductor o Número de Identificación del Estado  Driver’s License / State ID Number | | | | | | |  | Estado donde le otorgaron la lic.  State of Issue | | | | |  | | ¿Dónde vive actualmente?  Where Are You Currently Living? | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |  | | |  | | | | | |
| Dirección Postal (Calle ó Casilla de Correo)  Mailing Address (Street or PO Box) | | | | | | | | | | | | | | | | | | |  | | | Ap  Unidad  N° de Suite  Apt Unit Suite # | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | |  |  |  |  | | | | | | | | | | | | |  |  | |
| Ciudad  City | | | | | | | | | Estado  State | Código Postal  Zip | | | | | | | | | | | | | Condado de Residencia  County of Residence | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |  | | |  | | | | |
| Dirección Actual  Igual que la de arriba  Street Address Where You Are Currently Living Same as Mailing Address | | | | | | | | | | | | | | | | | | | |  | | | Ap  Unidad  N° de Suite  Apt Unit Suite # | | | | |
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| Ciudad  City | | | | | | | | |  | Estado  State | | | |  | | Código Postal  Zip | | | | | | | | | | | |
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| Teléfono de Casa  Home Phone |  | | | Teléfono Celular  Cell Phone | | | | | | | | | | | | |  | Teléfono del Trabajo  Business Phone | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **LUGAR DE NACIMIENTO** | | | *PLACE OF BIRTH* | | | | | | | | | | | | | | | | | | | | | | | | |
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| Condado de nacimiento en CA  CA County of Birth | |  | | | Estado de nacimiento en los EE.UU.  US State of Birth | | | | | | | | | | | | | | | |  | | | País donde Nació  Country of Birth | | | |

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| **IDIOMA / RELIGION** | | | | *LANGUAGE / RELIGION* | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
|  | | | | | | | | |  | | |  | | | | |
| Primer Idioma  Primary Language | | | | | | | | |  | | | Segundo Idioma  Secondary Language | | | | |
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|  | | | | | | | | |  | |  | | | | | |
| Idioma Preferido  Preferred Language | | | | | | | | |  | | Idioma que Habla la Familia  Family Language | | | | | |
|  | | | | | | | | | | | | | | | | |
| Lo domina  Fluent | | Limitada  Limited | | | | Ninguna  None | | |  | | |  | | | | |
| Habilidad Verbal en Inglés  English Verbal Proficiency | | | | | | | | |  | | | Preferencia Religiosa  Religious Preference | | | | |
| **ORIGEN ETNICO** | | | *ETHNICITY* | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **¿Es Ud. Español, Hispano o Latino?**  Are You Spanish, Hispanic or Latino? | | | | | | | | Si  Yes | | No  No | | | Desconocido  Unknown | | |  | |
|  | | | | | | | | | | | | | | | | | |
| **Por favor indique hasta dos etnias que mejor lo describan:**  “**1**” para Primaria y “**2**” para Secundaria  Please Indicate Up to Two Ethnicities That Best Describe You: **“1”** for Primary and **“2”** for Secondary | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| \_\_\_ | Aleutiano  Aleut | | | | \_\_\_ | | Nativo de Hawaii  Hawaiian Native | | | | | | | \_\_\_ | Pakistaní  Pakistani | | |
| \_\_\_ | Argelino  Algerian | | | | \_\_\_ | | Hispano/Otro  Hispanic-Other | | | | | | | \_\_\_ | Palestino  Palestinian | | |
| \_\_\_ | Amerasiatico  Amerasian | | | | \_\_\_ | | Indian (Asiatico)  Indian (Asian) | | | | | | | \_\_\_ | Portoriqueño  Puerto Rican | | |
| \_\_\_ | Bangladeshi  Bangladeshi | | | | \_\_\_ | | Iraní  Iranian | | | | | | | \_\_\_ | Samoano  Samoan | | |
| \_\_\_ | Afro-Americano/Negro  Black / African-American | | | | \_\_\_ | | Iraquí  Iraqi | | | | | | | \_\_\_ | Somalí  Somalian | | |
| \_\_\_ | Camboyano  Cambodian | | | | \_\_\_ | | Japonés  Japanese | | | | | | | \_\_\_ | Sur o Centro-Americano  South or Central American | | |
| \_\_\_ | Caucasico / Europeo / Blanco  Caucasian/European/White  Chino | | | | \_\_\_ | | Coreano  Korean | | | | | | | \_\_\_ | Español  Spanish | | |
| \_\_\_ | \_\_\_ | | Laosiano  Laotian | | | | | | | \_\_\_ | Ceilanés  Srilankan | | |
| \_\_\_ | Chinese  Cubano | | | | \_\_\_ | | Libanés  Lebanese | | | | | | | \_\_\_ | Tailandés  Thai | | |
| \_\_\_ | Cuban  Egipcio | | | | \_\_\_ | | Mexicano  Mexican | | | | | | | \_\_\_ | Vietnamita  Vietnamese | | |
| \_\_\_ | Egyptian  Esquimal | | | | \_\_\_ | | Indio Americano  Native American | | | | | | | \_\_\_ | Desconocido  Unknown | | |
| \_\_\_ | Eskimo  Filipino | | | | \_\_\_ | | Otro Asiático  Other Asian | | | | | | | \_\_\_ | Prefiere No Contestar  Decline to State | | |
| \_\_\_ | Filipino  Guamanian | | | | \_\_\_ | | Isleño del Pacífico  Pacific Islander | | | | | | | \_\_\_ | Otro  Other | | |
|  | Guamanian | | | | (pero no Hawaiano / Guames / Samoano)  (Not Hawaiian / Guamanian / Samoan) | | | | | | | | | | | | |

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| **información familiar** | | | | | *FAMILY INFORMATION* | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Estado Civil**  Client Marital Status | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Soltero  Single | | | Casado  Married | | | | | | | | | | | | | | Divorciado  Divorced | | | | | | | | | | | | Separado  Separated | | |
| Viudo  Widowed | | | Pareja de Hecho  Domestic Partnership | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
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| **Para cuántas personas es usted el Cuidador Principal?**  For how many people are you the Primary Caregiver? | | | | | | | | | | | | | | | | | | | | | | **Hasta la edad de 17 años**  Through Age 17 | | | | | | | | | |
| *Definición del Cuidador Principal: 50% o más de su tiempo* | | | | | | | | | | | | | | | | | | | | | | **18 o mayor**  18 or Older | | | | | | | | | |
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| Apellido de la Madre  Mother’s Last Name | | | | | |  | | Primer Nombre de la Madre  Mother’s First Name | | | | | | | | | | | | | | | |  | | Segundo Nombre de la Madre  Mother’s Middle Name | | | | | |
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| Apellido de Soltera de la Madre  Mother’s Maiden Name | | | | | |  | | Fecha de nacimiento de la madre  Mother’s Date of Birth | | | | | | | | | | | | | | | | | | | | | | | |
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| Apellido del padre  Father’s Last Name | | | | | |  | | Primer nombre del padre  Father’s First Name | | | | | | | | | | | | | | | |  | | Segundo Nombre del padre  Father’s Middle Name | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **INFORMACIÓN DE EMPLEO DEL CLIENTE** | | | | | | | | | | | | | | | | *CLIENT EMPLOYMENT INFORMATION* | | | | | | | | | | | | | | | |
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| **Por favor seleccione la opción que mejor describe su situación de empleo actual:**  Please selelct the option that best describes your current employment status | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Competitivo F/T (> 34hrs/wk)  Competitive F/T (>34hrs/wk) | | | | | | | | | | No-Competitivo F/T (> 34hrs/wk)  Non-Competitive F/T (>34hrs/wk) | | | | | | | | | | | | | | | | | | | Estudiante  Student | | |
| Competitivo P/T (<35hrs/wk)  Competitive P/T (<34hrs/wk) | | | | | | | | | | No-Competitivo P/T (<35hrs/wk)  Non-Competitive P/T (<34hrs/wk) | | | | | | | | | | | | | | | | | | | Ama de Casa  Homemaker | | |
| Retiredo/a  Retired | | Voluntario/a  Volunteer | | | | | Buscando trabajo  Actively Looking | | | | | | | | | | | | | Residente/Preso  Resident / Inmate | | | | | | | | | Otro  Other | | |
| ***Definición de Empleo Competitive y No-Competitivo:***  ***Empleo Competitive*** *= Empleo pago en la comunidad, en una posición que está disponible también para personas que no son discapacitadas. Esto podría incluir posiciones que tienen servicios de apoyo en el lugar de trabajo o fuera del mismo (Empleo con Apoyo).*  ***Empleo******No-Competitivo*** *= Trabajos pagos en la comunidad que están disponibles solamente para personas discapacitadas*. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Ocupación  Occupation | | | | | | | | | | | | | | |  | | Empleador  Employer | | | | | | | | | | | | | | |
| **INFORMACIÓN ESCOLAR DEL CLIENTE** | | | | | | | | | | | | | | *CLIENT SCHOOL INFORMATION* | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Nivel de Educación Cumplido:**  Highest Education Completed: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Jardín de Infantes  Kindergarten | | | | 1er. Grado  1st Grade | | | | | | | | 2do Grado  2nd Grade | | | | | | | 3er Grado  3rd Grade | | | | | | | | 4° Grado  4th Grade | | | 5° Grado  5th Grade |
| 6° Grado  6th Grade | | | | 7° Grado  7th Grade | | | | | | | | 8° Grado  8th Grade | | | | | | | 9° Grado  9th Grade | | | | | | | | 10° Grado  10th Grade | | | 11° Grado  11th Grade |
| 12° Grado (Graduado de HS o GED)  12th Grade (HS Grad or GED) | | | | | | | | | | | | | 1° Año Univ.  1st Year College | | | | | | | | | | Título de Asociado  Associate Degree | | | | | | | |
| 3° Año Univ.  3rd Year College | | | | Licenciatura  Bachelor’s Degree | | | | | | | | | 1 Año de Graduado  1st Year Grad Work | | | | | | | | | | | | | | | Título de Maestría  Master’s Degree | | |
| 3° Año de Grad.  3rd Year Grad Work | | | | Doctorado  Doctorate | | | | | | | | | Ninguno  None | | | | | | | | Desconocido  Unknown | | | | | | | | Otro  Other | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Nombre de la escuela donde asiste  Name of School Attending | | | | | | | | |  | | Nombre de persona de contacto en la escuela  Name of School Contact | | | | | | | | | | | | |  | Número de teléfono de la persona de contacto  Contact’s Phone Number | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **GENERAL MEDICAL CONDITIONS** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
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| **Indique cualquier condición médica general:** Usé "**1**" para primaria y "**2**" para secundaria  Seleccione una marca de verificación junto a las condiciones médicas generales adiciones,  si usted tiene más de dos (2).  Please Indicate Any General Medical Conditions: List **“**1**”** for Primary and **“**2**”** for Secondary.  Place a check mark next to any additional General Medical Conditions if you have more than two (2). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \_\_\_\_ | Paciente niega cualquier condición médica  Patient Denies Any Medical Conditions | | | | | | | | | | | | | | | | | \_\_\_\_ | | Síndrome del túnel Carpiano  Carpal Tunnel Syndrome | | | | | | | | | | |
| \_\_\_\_ | Alergias  Allergies | | | | | | | | | | | | | | | | | \_\_\_\_ | | Enfermedad Pulmonar Obstructiva Crónica  Chronic Obstructive Pulmonary Disease (COPD) | | | | | | | | | | |
| \_\_\_\_ | Anemia  Anemia | | | | | | | | | | | | | | | | | \_\_\_\_ | | Cirrosis  Cirrhosis | | | | | | | | | | |
| \_\_\_\_ | Enfermedad Arterial Esclerótica  Arterial Sclerotic Disease | | | | | | | | | | | | | | | | | \_\_\_\_ | | Trastornos Congénitos  Congenital Disorders | | | | | | | | | | |
| \_\_\_\_ | Asma  Asthma | | | | | | | | | | | | | | | | | \_\_\_\_ | | Insuficiencia Cardíaca Congestiva  Congestive Heart Failure | | | | | | | | | | |
| \_\_\_\_ | Dolor de Espalda/ Cuello  Back / Neck Pain | | | | | | | | | | | | | | | | | \_\_\_\_ | | Fibrosis Quística  Cystic Fibrosis | | | | | | | | | | |
| \_\_\_\_ | Ciego / Visualmente Discapacitado  Blind / Visually Impaired | | | | | | | | | | | | | | | | | \_\_\_\_ | | Sordo / Discapacidad Auditiva  Deaf / Hearing Impaired | | | | | | | | | | |
| \_\_\_\_ | Trastorno Sanguíneo (Aparte de Anemia)  Blood Disorder (other than Anemia) | | | | | | | | | | | | | | | | | \_\_\_\_ | | Demencia  Dementia | | | | | | | | | | |
| \_\_\_\_ | Cancer  Cancer | | | | | | | | | | | | | | | | | \_\_\_\_ | | Trastorno Dermatológico / Lesiones de la piel  Dermatologic Disorder / Skin Lesions | | | | | | | | | | |

***Continúa en la página siguiente***

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| --- | --- | --- | --- |
| \_\_\_\_ | Diabetes  Diabetes | \_\_\_\_ | Distrofia Muscular  Muscular Dystrophy |
| \_\_\_\_ | Trastorno Digestivo  Digestive Disorder | \_\_\_\_ | Problema Musculoesquelético  (No de la espalda / Cuello)  Musculoskeletal Problem (not back / neck) |
| \_\_\_\_ | Infecciones de oídos  Ear Infections | \_\_\_\_ | Trastorno Neurológico  Neurologic Disorder |
| \_\_\_\_ | Trastornos Endocrinos  Endocrine Disorder | \_\_\_\_ | Obesidad  Obesity |
| \_\_\_\_ | Epilepsia / Convulsiones  Epilepsy / Seizures | \_\_\_\_ | Osteoartritis  Osteoarthritis |
| \_\_\_\_ | Problemas de la Vesícula Biliar  Gall Bladder Problems | \_\_\_\_ | Osteoporosis  Osteoporosis |
| \_\_\_\_ | Trastorno Genitourinario  Genitourinary Disorder | \_\_\_\_ | Dolor (Crónico)  Pain (Chronic) |
| \_\_\_\_ | Enfermedad de Reflujo Gastroesofágico  GERD | \_\_\_\_ | Enfermedad de Parkinson  Parkinson’s Disease |
| \_\_\_\_ | Dolores de Cabeza (No migrañas)  Headaches (not Migraines) | \_\_\_\_ | Discapacidad Física  Physical Disability |
| \_\_\_\_ | Enfermedad Cardíaca  Heart Disease | \_\_\_\_ | Psoriasis  Psoriasis |
| \_\_\_\_ | Hepatitis  Hepatitis | \_\_\_\_ | Insuficiencia Renal / Enfermedad  Renal Failure / Disease |
| \_\_\_\_ | Hipercolesterolemia  Hypercholesterolemia | \_\_\_\_ | Artritis Reumatológico  Rheumatologic Arthritis |
| \_\_\_\_ | Hiperlipidemia  Hyperlipidemia | \_\_\_\_ | Trastorno Reumatológico  Rheumatologic Disorder |
| \_\_\_\_ | Hipertensión  Hypertension | \_\_\_\_ | Enfermedad Transmisible Sexualmente (ETS)  Sexually Transmitted Disease (STD) |
| \_\_\_\_ | Hipertiroidismo  Hyperthyroid | \_\_\_\_ | Embolio  Stroke |
| \_\_\_\_ | Hiportiroidismo  Hypothyroid | \_\_\_\_ | Tinnitus  Tinnitus |
| \_\_\_\_ | Trastorno Inmunológico  Immunologic Disorder | \_\_\_\_ | Ulceras  Ulcers |
| \_\_\_\_ | Infertilidad  Infertility | \_\_\_\_ | Bajo de Peso  Underweight |
| \_\_\_\_ | Migrañas  Migraines | \_\_\_\_ | Otro  Other |
| \_\_\_\_ | Esclerosis Múltiple  Multiple Sclerosis | \_\_\_\_ | Desconocido / No Fue Posible de Evaluar  Unknown / Not Able to Assess |

|  |  |
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| **información de referencia** | *REFERRAL INFORMATION* |
|  | |
| Cómo se enteró de nuestros servicios?  How did you find out about our services? | |

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| **contacto para casos de emergencia** | | | *EMERGENCY CONTACTS* | | | | | | | | | | | | |
| ¿A quién podemos llamar en caso de emergencia? | | | *Who should we contact in case of an emergency?* | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Primario** – Relación del Cliente con el Contacto:  Primary - Client’s Relationship to Emergency Contact | | | | | | | | | | | | | | | |
|  | | | | |  | | |  | | | | | | | |
| Nombre y Apellido  Name (Last, First) | | | | |  | | | Dirección  Address | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | |  | | |  | | | | |  | |  |
| Ciudad  City | | | | |  | | | Estado  State | | | | |  | | Código Postal  Zip |
|  | | | | | | | | | | | | | | | |
|  |  |  | | | | | | | |  |  | | | | |
| Teléfono de Casa  Home Phone |  | Teléfono del Trabajo / Ext  Business Phone / Ext. | | | | | | | |  | Teléfono Celular  Cell Phone | | | | |
|  | | | | | | | | | | | | | | | |
| **Secundario** – Relación del cliente con el contacto  Secondary - Client’s Relationship to Emergency Contact | | | | | | | | | | | | | | | |
|  | | | | | |  | | |  | | | | | | |
| Nombre y Apellido  Name (Last, First) | | | | | |  | | | Dirección  Address | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | |  | | |  | | | | |  | |  | |
| Ciudad  City | | | |  | | | Estado  State | | | | |  | | Código Postal  Zip | |
|  | | | | | | | | | | | | | | | |
|  |  |  | | | | | | | |  |  | | | | |
| Teléfono de Casa  Home Phone |  | Teléfono del Trabajo / Ext  Business Phone / Ext. | | | | | | | |  | Teléfono Celular  Cell Phone | | | | |

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| **información del tutor** | *CONSERVATORSHIP* | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| ¿Está Ud. bajo Tutoría?  Si  No  Desconocido  Are You on Conservatorship? Yes No Unknown | | | | | | | |  |  | | | | | | |
|  | | | | | | | |  | Cliente Relación con el Tutor  Client Relationship to Conservator | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | |  | |  | | | | | | |  |  | | |
| Apellido del Tutor  Conservator Last Name | | |  | | Primer Nombre del Tutor  Conservator First Name | | | | | | |  | Segundo Nombre del Tutor  Conservator Middle Name | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | |  |  | | | | |
| Dirección Postal del Tutor (Calle o Casilla de Correo)  Conservator Mailing Address (Street or PO Box) | | | | | | | | | | | Ap  Unidad  N° de Suite  Apt Unit Suite # | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | |  |  | | | | | | |  |  |
| Ciudad donde vive el Tutor  Conservator Mailing Address City | | | | | |  | Estado  State | | | | | | |  | Código Postal  Zip |
|  | | | | | | | | | | | | | | | |
|  | |  | |  | | | | | | | |  |  | | |
| Teléfono de Casa  Home Phone | |  | | Teléfono Celular  Cell Phone | | | | | | | |  | Teléfono del Trabajo / Ext  Business Phone / Ext | | |
|  | | | | | | | | | | | | | | | |
|  | |  | |  | | | | | | | |  | | | |
| Número del Caso Judicial  Court Case Number | |  | | ¿Es el Tutor PAPG o Privado?  Is Conservator PAPG or Private? | | | | | | | |  | | | |
|  | | | | | | | | | | | | | | | |

**ALTO**

Las dos últimas páginas son solo para uso clínico.

Por favor, devuelva este paquete al personal de recepción.

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| **FOR CLINICIAN USE ONLY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **CLIENT DEMOGRAPHICS** | | | | | | | | | | | | | | | | | **Admission Living Arrangement** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1-12 (Group Home Level)  13-14 (Group Home Level)  Acute Psychiatric Inpatient  Board and Care  Cerritos College Hospital  Coastal Community Hospital  Convalescent Home  Costa Mesa College Hospital  Daily Support Req in House/Apt  Extended Care West Anaheim  Extended Care Westminster  Foster Care  Homeless/No Identifiable Res.  IMD (Institution for Mental Disease) | | | | | | | | | | | | | | | | | | | Jail/Correctional Facility  JH (Juvenile Hall)  Joplin Youth Camp  Kaiser Hospital  Medical Hospital  MHRC (MH Rehab Center)  No Support Req in House/Apt  Non-Contracted Facility  OCFC (Orangewood)  Out of State Res Tx Center  Parent/Guardian Home (Minor)  Prison  Psychiatric Hospital - Other  Psychiatric Residential Tx Center | | | | | | | | | | | | | | | | | | Regional Center Group Home  Residential/Recovery Facility  Res Rehabilitation Facility  RFE (Res Facility for the Elderly)  Room and Board  RTRC (Santa Ana Royale)  Shelter  SNF (Skilled Nursing)  Sober Living Home  Social Rehab Facility  Some Support Req in House/Apt  State Hospital  STEPs MHRC  STEPs Res Rehab Facility | | | | | | | | | Supported Housing  UCI Med Center  VA Hospital  WMA (West Med – Anaheim)  YGC (Youth Guidance Center)  YLA (Youth Leadership Academy)  Unknown/Not Reported  Other: | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SCHOOL INFORMATION** | | | | | | | | | | | | | | | | | | For Educationally Related Mental Health Services (ERMHS) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ERMHS Referral**: | | | | | | No | | | | | Yes | | | | | | | | | | **Home School District:** | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Special Education Eligibility** (per IEP) | | | | | | | | | | | | | | | | | | | | | | | | Not Applicable | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Autism | | Deaf-Blind | | | | | | | | | | | | | | | | | Deaf/Hard of Hearing | | | | | | | | | | | | | | | | | Developmental Delays (Ages 3-9) | | | | | | | | | | Emotionally Disturbed | | | | | |
| Limited IQ | | | | | | | | | | | | | | | | | | | Non-Cat/Med Condition (0-5) | | | | | | | | | | | | | | | | | Orthopedically Impaired | | | | | | | | | | Other Health Impaired | | | | | |
| Specific Learning Disability | | | | | | | | | | | | | | | | | | | Speech & Language Impaired | | | | | | | | | | | | | | | | | Traumatic Brain Injury | | | | | | | | | | Visually Impaired | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Special Education Setting** (per IEP) | | | | | | | | | | | | | | | | | | | | | | | | | Not Applicable | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Home Instruction | | | | | | | | Non-Public School | | | | | | | | | | | | | | | | | Regular Classroom | | | | | | | | | | RSP (Resource Specialized Program) | | | | | | | | | | | | SDC (Special Day Class) | | | | |
| State School | | | | | | | | Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **ENCOUNTER INFORMATION** | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Program Specialty** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | Not Applicable | | | | | | | | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
| **BHS Special Population** | | | | | | | | | | | | **CalWORKS** | | | | | | | | | | | | | | | **None** | | | | | | | | | | | | | | | | | | | | | | | | |
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| **TX TEAM INFORMATION** | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **HCA Providers** | | | (Last Name, First Name) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Psychiatrist / Nurse Practitioner | | | | | | | | | | | | | | | | | | | | | |  | | | | Medical Physician / Nurse Practitioner | | | | | | | | | | | | | | |  | | Care Coordinator / Case Manager | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | |  | |  | | | | | | | |  |
| Clinician | | | | | | | | | | | | | | | | | | | | | |  | | | | Auxiliary Service Provider | | | | | | | | | | | | | | |  | | Auxiliary Provider Type | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | |  | |  | | | | | | | |  |
| Service Chief / Program Director | | | | | | | | | | | | | | | | | | | | | |  | | | | CYS MHSA Tx Provider Type | | | | | | | | | | | | | | |  | |  | |  | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **LEGAL INFORMATION** | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Court / Conservator Status** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| PC2974 | Probate 1400 | | | | | | | | | | | | | | W300 Juvenile Dependent | | | | | | | | | | | | | | | | | W5008 (Murphy Conservator) | | | | | | | | | | | | W5353 (Temp Conservator) | | | | | | | |
| W5358 LPS Conservator | | | | | | | | | | | | | | | W5686 | | | | | | | | | W601 Juvenile Status Ward | | | | | | | | | | | | | | | W602 Juvenile Ward | | | | | N/A | | | Unknown/Not Reported | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **W & I Code Legal Class** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other - Civil Involuntary Status | | | | | | | | | | | | | | Other - Criminal Involuntary Status | | | | | | | | | | | | | | | | | | | | PC1026 | | | | | | PC1370 | | PC2684 | | | | PC47.6, 47.8 | | |  | | |
| Sexual Psychopathy / Related Categories | | | | | | | | | | | | | | | | | | | | | | | W5150 | | | | | | W5250 | | | | | W5260 | | | | | | W5270.15 | | W5300 | | | | W5585 | | W6000 | | W709 | |
| N/A | | | | Unknown/Not Reported | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
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| **EOC INFORMATION** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **EOC Start Date** | | | | | \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | **EOC Name** | | | | | | | | | | | | | | | | | | | | |

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| **FOR SAME DAY ADMISSION AND DISCHARGE** | | | | | |  | | | | | | | | |
| **Behavioral Health Treatment Linkage / Referral** | | | | | | |  | | | | | | | |
| ADAS Community Support | | | | | AMHS STEPs LPS | | | | | | | CYS Youth Resource Center | | |
| ADAS Medical Detox | | | | | AMHS STEPs MHRC | | | | | | | Domestic Violence Shelter | | |
| ADAS Outpatient | | | | | ASO (Administrative Services Organization) | | | | | | | Out of County Behavioral Health Service | | |
| ADAS Residential | | | | | CYS CAST | | | | | | | Non-Profit Organization | | |
| ADAS Social Detox | | | | | CYS CAT | | | | | | | PCP (Primary Care Physician) | | |
| AMHS Adult Outpatient Services | | | | | CYS CCPU | | | | | | | PEI OC CREW | | |
| AMHS Collaborative Court | | | | | CYS CEGU OCFC | | | | | | | Psychiatrist Private | | |
| AMHS Extended Care West | | | | | CYS CEGU Probation | | | | | | | Residential Tx Center for Children | | |
| AMHS Extended Care West Anaheim | | | | | CYS Contract Regional Outpatient | | | | | | | Student Health Service | | |
| AMHS FSP | | | | | CYS County Regional Outpatient | | | | | | | Therapist Private | | |
| AMHS LPS Unit (Lanterman - Petris - Short) | | | | | CYS CSP Children’s Residential Program | | | | | | | VA Health Care | | |
| AMHS Recovery Center | | | | | CYS FSP | | | | | | |  | | |
| AMHS OAS (Older Adult Services) | | | | | CYS Juvenile Drug Court | | | | | | | Client Declined Referral | | |
| AMHS PACT(Program Assertive Community Treatment) | | | | | CYS OC CAPC (In Home Crisis) | | | | | | | Client Unavailable for Referral | | |
| AMHS PACT TAY | | | | | CYS Phoenix Academy | | | | | | | N/A No Referral | | |
| AMHS Royale MHRC | | | | | CYS SCCS TAY Crisis Residential Program | | | | | | | Other | | |
| AMHS Royale TRC | | | | | CYS SCCS TAY Social Rehabilitation Program | | | | | | |  | | |
| AMHS SHOPP | | | | | CYS Touchstones | | | | | | |  | | |
|  | | | | | | | | | | | | | | |
| **Discharge Reason** | | | | | | | | | | | |  | | |
| Client Declined Services | Hospitalized | | | Linked to BHS Contract Provider | | | | | | Linked to BHS Provider | | | | Linked to non-BHS Provider |
| Does Not Meet Medical Necessity (NOA) | | | Does Not Meet Program Criteria | | | | | Other: | | | | | | |
|  | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | |
| **Facility EOC / Discharge Date** | | **\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | |
| **EOC Name** | | ­­­­­­­­­­­­ | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Provider Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | **Office Staff** | | | | | |
| **Initials** | |  | | | |
| **Print / Type Name:** | | | | | | | | | **Date Processed:** | | | | **\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_** | |