HORIZONS
MENTAL HEALTH CENTER
A Member of the Hutchinson Regional Healthcare Family

ADMISSION INFORMATION

CLIENT NAME (please print): _____ DOB: _____
Name of person completing form if not client: _____
Relationship to client: _____

Custody Status (for youth): ☐ DCF (lives at home) ☐ DCF (out of home)
☐ DCF Sup (not in custody) ☐ No DCF involvement

Who Referred you to Horizons? _____

Do you know anyone working for Horizons? ☐ Yes ☐ No
Employee's Name: _____

Do you have a primary care doctor? ☐ Yes ☐ No Name:_____

List any other healthcare professionals (doctor, therapist, etc) you see:

_____

Please list the reason(s) that bring you here today. This may include concerns, problems, significant losses or changes that are causing you to seek treatment at this time.

_____
_____
_____

Please select the services you are interested in receiving:
☐ Medication Management ☐Therapy ☐Case Management ☐Intake Only
☐ Substance Use Treatment ☐I Don't Know

MARITAL STATUS: ☐Never Married ☐Married ☐Divorced
☐Other Relationship ☐Not Applicable

Gender/Sexual Orientation

GENDER ASSIGNED AT BIRTH: ☐Male ☐ Female

GENDER IDENTITY: ☐Male ☐Female ☐ Gender Queer
☐Transgender Female/Transwoman/MTF ☐Transgender Male/Transman/FTM
☐Decline to answer ☐Other: _____

PREFERRED PRONOUN: ☐ she/her/hers ☐ he/him/his ☐ they/them/theirs
SEXUAL ORIENTATION: ☐ Straight (heterosexual) ☐Lesbian or Gay ☐Bisexual
☐ Asexual ☐ Pansexual ☐ Queer ☐ Questioning ☐ Choose not to disclose

Educational Information
Highest level of education complete: _____
Current educational placement:

Ethnicity/Race/Primary Language	
Are you Hispanic or Latino?	☐Yes ☐No
If yes, what ethnic group?	☐ Central American ☐ Cuban ☐ Dominican ☐ Mexican ☐ Puerto Rican ☐ South American ☐ Other: _____
Race	☐ Black/African American ☐ Asian ☐ White ☐ Alaska Native ☐ American Indian ☐ Other/Unknown ☐ Native Hawaiian/Pacific Islander
Primary Language	☐English ☐Spanish ☐ American Sign Language ☐Other:

Current Smoking Status
Do you currently smoke tobacco? ☐ Yes ☐No

Military History
Have you served in the military? ☐ Yes ☐ No If yes, which branch? You may mark more than one. ☐ Armed Forces ☐ National Guard ☐ Reserves
Are you currently serving on active duty? ☐ Yes ☐ No

Income and Benefit Information	
Annual household income:	
Currently receiving SSI Benefits?	☐ Eligible and <u>not</u> receiving ☐ Eligible and receiving ☐ Ineligible ☐ Not Applicable ☐ Potentially Eligible
Currently receiving SSDI Benefits?	☐ Eligible and <u>not</u> receiving ☐ Eligible and receiving ☐ Ineligible ☐ Not Applicable ☐ Potentially Eligible

GAD-7 (11 years old and up) **Over the last 2 weeks, how often have you been bothered by any of the following problems?**	Not at All (0)	Several Days (1)	More than half of the days (2)	Nearly every day (3)
1. Feeling nervous, anxious or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying to much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid, as if something awful might happen	☐	☐	☐	☐
FOR OFFICE USE: ADD COLUMNS				
FOR OFFICE USE: Total Score				

PHQ-9 (11 years old and up) **Over the last 2 weeks, how often have you been bothered by any of the following problems?**	Not at All (0)	Several Days (1)	More than half of the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or over eating	☐	☐	☐	☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself	☐	☐	☐	☐
FOR OFFICE USE: ADD COLUMNS				
FOR OFFICE USE: Total Score				

10. 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	☐