County of San Luis Obispo Behavioral Health

Client Information

Social Security Number: _____

Prefix ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms.

Client Name: _____
(First) (Middle) (Last)

Email: _____

Medicaid ID: _____ Medicare Beneficiary ID: _____

Phone Number #1: _____ Type: ☐ Home ☐ Cell ☐ Business ☐ Other
☐ Do Not Call ☐ Do Not Leave a Message

Phone Number #2: _____ Type: ☐ Home ☐ Cell ☐ Business ☐ Other
☐ Do Not Call ☐ Do Not Leave a Message

Street Address: _____ City/State/Zip Code: _____

Mailing Address: ☐ Yes ☐ No If no, please complete below.

Mailing Address: _____ City/State/Zip Code: _____

Client Aliases

Client Name: _____
(First) (Middle) (Last)
Type: ☐ Nickname ☐ Preferred Name ☐ Former Name ☐ Alias

Client Name: _____
(First) (Middle) (Last)
Type: ☐ Nickname ☐ Preferred Name ☐ Former Name ☐ Alias

Demographics

Date of Birth: _____ Sex Assigned at Birth: ☐ Male ☐ Female ☐ Not Listed

Marital Status:
☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Widowed
☐ Never Married ☐ Unknown

County of San Luis Obispo Behavioral Health

Client Information

Gender Identity:

☐ Male ☐ Female ☐ Non-Binary ☐ Unsure/Questioning ☐ Other
☐ Female-to-Male (FTM)/Transgender Male/Trans Man ☐ Prefer not to answer
☐ Male-to-Female (MTF)/Transgender Female/Trans Woman ☐ Unknown/Not Asked
☐ Genderqueer, neither exclusively male nor female

Sexual Orientation:

☐ Heterosexual / Straight ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Asexual
☐ Pansexual ☐ Queer ☐ Unsure/Questioning ☐ Prefer not to answer ☐ Other
☐ Unknown/Not Asked

Pronoun: ☐ He ☐ She ☐ They ☐ Ze

Ethnicity:

☐ Hispanic or Latino ☐ Hispanic or Latino-Dominican ☐ Hispanic or Latino-Mexican
☐ Hispanic or Latino-Other ☐ Not Hispanic or Latino ☐ Prefer not to answer
☐ Unknown/Not Reported

Race:

☐ Alaskan Native/American Indian ☐ AN/AI-Alaska Native ☐ AN/AI-American Indian
☐ AN/AI-Other ☐ Asian-Asian Indian ☐ Asian-Cambodian ☐ Asian-Chinese
☐ Asian-Filipino ☐ Asian-Hmong ☐ Asian-Japanese ☐ Asian-Korean ☐ Asian-Laotian
☐ Asian-Mien ☐ Asian-Vietnamese ☐ Asian-Other ☐ Black/African American
☐ Black/AA-African American ☐ Black/AA-Black ☐ Black-AA-Other
☐ Middle Eastern/North African ☐ Middle Eastern/N.African-Middle Eastern
☐ Middle Eastern/N.African-North African ☐ Middle Eastern/N.African-Other
☐ Native Hawaiian/Other Pacific Islander ☐ NH/Other PI-Native Hawaiian
☐ NH/Other PI-Carolinian ☐ NH/Other PI-Samoan ☐ NH/Other PI-Other
☐ White ☐ Multiracial ☐ Other ☐ Prefer not to answer ☐ Unknown

Language:

Primary/Preferred Language: _____

☐ Client Does not Speak English ☐ Interpreter Services Needed

Providers:

Primary Care Physician: _____ ☐ Does not have PCP

Financial Information

Financially Responsible: ☐ Yes ☐ No

Annual Household Income: $_____ # of Dependents: _____# in Household: _____

Source of Income:

☐ Wages/Salary ☐ Public Assistance ☐ Retirement/Pension ☐ Disability
☐ Other ☐ None ☐ Unknown ☐ Not collected

Living Arrangements:

☐ Homeless ☐ House or apartment (includes trailers, hotels, dorms, barracks, etc.)
☐ On the streets or in a homeless shelter ☐ Group Home ☐ Foster Family Home
☐ Residential Treatment Center ☐ Jail or Correctional Facility
☐ House or apartment, requiring daily support and supervision (adults only)
☐ Unknown/Not Reported ☐ Other:_____

Education/Employment:

Educational Status:

Currently Enrolled: ☐ Yes ☐ No Grade Level Enrolled: _____
Highest Grade Level Completed: _____
If enrolled in School, Name of School: _____
(Staff Only: School Name is added in Custom Fields)

Military Status: ☐ Yes ☐ No Veteran Status: ☐ Yes ☐ No

Employment Status:

☐ Employed Full Time ☐ Employed Part Time ☐ Unemployed Seeking Work
☐ Unemployed Not Seeking Work ☐ Student ☐ Ages 0-5 ☐ Retired
☐ Disabled Not in Workforce ☐ Other: _____

Criminal Justice Involvement:

☐ Probation ☐ Dept of Corrections ☐ Dept of Youth Services Commitment
☐ Jail ☐ Parole ☐ AB109 ☐ Court ☐ Not Involved

Transportation Information

☐ Transportation Services Needed

Special Needs

Note any special needs/accommodations (e.g. wheelchair, service animal)

Preferences

Communication Preference: ☐ Text Message ☐ Email ☐ Voice ☐ Do Not Send Any Notifications

Communication Phone Number: _____

Contacts

Contact #1 Information: Relationship: _____

Name _____ Date of Birth: _____
First Last

Email Address: _____ Organization: _____

☐ Financially Responsible ☐ Emergency Contact ☐ Guardian ☐ Household Member

☐ Care Team Member ☐ Healthcare Decision Maker

Phone #1: _____ Phone #2: _____

Address: ☐ Same as client Street Address: _____

City, State, Zip: _____

Preferred Language: _____ Primary Language: _____

Contact #2 Information: Relationship: _____

Name _____ Date of Birth: _____
First Last

Email Address: _____ Organization: _____

☐ Financially Responsible ☐ Emergency Contact ☐ Guardian ☐ Household Member

☐ Care Team Member ☐ Healthcare Decision Maker

Phone #1: _____ Phone #2: _____

Address: ☐ Same as client Street Address: _____

City, State, Zip: _____

Preferred Language: _____ Primary Language: _____