Client Name: _____

CHILD FOCUS
Strong families. Thriving communities.

Adult Outpatient Registration

Office Use Only (Registration Worker)

Date Submitted to Office:		1st Appointment Offered:			
		Fee Code (Medicaid, Private Insurance Company, Fee):			
911/DI Worker:	DATE:	Case #:			
			Group:		Individual

Please Print. Please read and complete ALL sections.

Client's Information		
Legal Name (last, first, middle):		Preferred/Chosen Name:
Pronouns:	Gender:	Sex assigned at birth:
SS#:	Date of Birth:	
Address:	County of Residence:	
City:	State:	Zip:
Home Phone:	Work Phone:	
Email Address:		
Military Status: ☐ No ☐ Yes (specify): _____ ☐ Active ☐ Inactive		
Primary language if other than English:		

Person to Contact in case of an Emergency	
Name	Pronouns:
Relationship:	Phone #:

Current Living Situation (check all that apply)			
	Own Home		Friend's Home
	Relative's Home		Experiencing Homelessness

	Client's Race: (Check All that apply):		Client's Ethnicity: (Check All that apply):
	Alaskan Native		Cuban
	Asian		Mexican
	Black/African American		Puerto Rican
	Native American/American Indian		Other Hispanic
	Native Hawaiian/Other Pacific Islander		Not Hispanic or Latino
	White		
	Biracial:		

Names and Ages of Your Children:				
Full Name:	Age:	Relation:	Does this child live with you?	
			Yes	No
			Yes	No
			Yes	No
			Yes	No

Client Name: _____

Other Community and Human Service Providers Involved (check all that apply):		Contact Name and Phone Number
	Children's/Job and Family Services	
	Domestic Relations Court / Other Court	
	Mental Health or other Health	
	Adult probation/parole	
	County DD	
	Other (specify):	

Are a person living with disabilities (check all that apply):			
	Communication Disorder		Service Animal Assistance Needs
	Visually Impaired		Other (specify)
	Hearing Impaired		None
	Physical Disability		

Name and Phone Number of Person or Agency that Referred you to Child Focus:
If self-referred, how did you hear about Adult Services at Child Focus?

What is bringing you here today? Please identify your current needs in writing. Your service provider will review what you have written so a detailed description is most helpful in assuring your needs are met.

_____

_____

_____

_____

Are you currently suicidal: ☐ No ☐ Yes *Are you currently homicidal* ☐ No ☐ Yes

If yes, please explain_____

At this time, I prefer ☐ In person services ☐ Telehealth services (via secure video conferencing)

☐ No preference, either is fine

Severity of Current Needs:

1	2	3	4	5	6	7	8	9	10

Very little impact on functioning Extreme impact on functioning

Please rate environmental supports for change

1	2	3	4	5	6	7	8	9	10

Very little support Much support

Client motivation to change

1	2	3	4	5	6	7	8	9	10

Very little motivation Very high motivation

_____ _____

Signature Date

Client Name: _____

Office Use Only for Crisis Services and/or Diagnostic Testing (Clinician)

Action taken if client is suicidal/homicidal:

	ICD 10 Code	DSM V Diagnosis
Dx1		
Dx 2		
Date Ongoing Appt. Offered:	Date Ongoing Appt. Scheduled:	Entered into Catt ☐ Offered ☐ Seen