College of Health and Human Services
Unified Clinics
WESTERN MICHIGAN UNIVERSITY

Behavioral Health Services Client Questionnaire

Name: _____ Date of Birth: _____

Gender: ◯ Male ◯ Female Home Phone: _____

Mobile Phone: _____ Other Phone: _____ ◯ No telephone

Emergency Contact

Name: _____ Relation: _____

Phone Number: _____ Is this contact your legal guardian? ◯ Yes ◯ No

Primary Care Physician

Name: _____ Phone number: _____

Address: _____

Referral Information

I was referred by: _____

Demographic Information

Current Living Arrangement: ◯ Dependent ◯ Homeless ◯ Independent

Current Address: _____

City: _____ State: ____ Zip code: _____ County: _____

Race ◯ Arab American ◯ Asian or Pacific Islander ◯ Black/African American ◯ Hispanic
◯ Multi Racial ◯ Native American/Indian ◯ White/Caucasian ◯ Prefer not to respond

Ethnicity: ◯ Arab/Chaldean ◯ Mexican ◯ Puerto Rican ◯ Other Hispanic ◯ None of these

Primary Language spoken: _____

Marital Status: ◯ Never Married ◯ Married/Cohabitating ◯ Widowed ◯ Separated ◯ Divorced

Military Status: ◯ Yes ◯ No

Education: _____

Currently ◯ In Special Education ◯ In Training Program ◯ Attending Undergraduate/Graduate School ◯ N/A

Employment Status: ◯ Employed full time ◯ Employed part time ◯ Unemployed
◯ Not in competitive labor force ◯ Not applicable

Total Annual Income: _____ Number of Dependents: _____

Correction Information

Correction Status: ◯ No status with corrections system ◯ Paroled from Prison ◯ Probation from Jail
◯ Juvenile Detention Center ◯ Court Supervision ◯ Awaiting Trial ◯ Awaiting Sentencing
◯ Decline to answer

Are you involved with any specialty court (drug, sobriety, veterans, mental health)? ◯Yes ◯No

If yes, which court system: _____ which county:_____

In the past 30 days….

How many times have you been arrested: _____

How many times for possession or sale of drugs/alcohol: _____ for DUI/DWI: _____

In the past 5 years….

How many times have you been arrested: _____

How many times for possession or sale of drugs/alcohol: _____ for DUI/DWI: _____

Treatment History

Have you received any other substance abuse treatment or other counseling services: ◯Yes ◯No

How many times have you tried to get this problem fixed? _____

History of Substance Use

Which substances have you used? Please check all that apply.

Substance	Age of First Use	Frequency	Date Last Used	Initially Prescribed?	Order of preference
◯ Alcohol				◯ Yes ◯ No	
◯ Heroin				◯ Yes ◯ No	
◯ Methadone (Illicit)				◯ Yes ◯ No	
◯ Other Opiates or Synthetics				◯ Yes ◯ No	
◯ Barbiturates				◯ Yes ◯ No	
◯ Other Sedatives or hypnotics				◯ Yes ◯ No	
◯ Other tranquilizers				◯ Yes ◯ No	
◯ Benzodiazepines				◯ Yes ◯ No	
◯ GHB/GBL				◯ Yes ◯ No	
◯ Cocaine				◯ Yes ◯ No	
◯ Crack Cocaine				◯ Yes ◯ No	
◯ Methamphetamines				◯ Yes ◯ No	
◯ Amphetamines				◯ Yes ◯ No	
◯ Methcathinone				◯ Yes ◯ No	
◯ Hallucinogens				◯ Yes ◯ No	
◯ PCP				◯ Yes ◯ No	
◯ Marijuana/Hashish				◯ Yes ◯	

				No	
◯ Ecstasy (MDMA, MDA)				◯ Yes ◯ No	
◯ Ketamine				◯ Yes ◯ No	
◯ Inhalants				◯ Yes ◯ No	
◯ Antidepressants				◯ Yes ◯ No	
◯ Over-the-counter				◯ Yes ◯ No	
◯ Steroids				◯ Yes ◯ No	
◯ Talwin and PBZ				◯ Yes ◯ No	
◯ Other				◯ Yes ◯ No	

Client Signature: _____ Date: _____

Health Conditions Measures

The agency that is funding your treatment, KCMHSAS, is required to gather the following information. We, at USAC, are also interested to help if you are experiencing difficulties in any of the areas listed below. Please read and rate the following:

Hearing

Ability to hear (with hearing appliance normally used)

- ◯ Adequate—No difficulty in normal conversation, social interaction, listening to TV
- ◯ Minimal difficulty—Difficulty in some environments (e.g., when person speaks softly or is more than 6 feet away)
- ◯ Moderate difficulty—Problem hearing normal conversation, requires quiet setting to hear well
- ◯ Severe difficulty—Difficulty in all situations (e.g., speaker has to talk loudly or very slowly; or hearing speech as mumbled)
- ◯ No hearing

Hearing aid used **(HEARAID)** ◯ Yes ◯ No

Vision

Ability to see in adequate light (with glasses or with other visual appliance normally used)

- ◯ Adequate—Sees fine detail, including regular print in newspapers/books or small items in pictures
- ◯ Minimal difficulty—Sees large print, but not regular print in newspapers/books or cannot identify large objects in pictures
- ◯ Moderate difficulty—not able to see newspaper headlines or items in pictures, but can identify objects in the environment
- ◯ Severe difficulty—Difficulty identifying objects, but eyes follow objects, or you see only light, colors, shapes
- ◯ No vision—eyes do not appear to follow objects; absence of sight

Visual appliance **(VISAPP)** ◯ Yes ◯ No

Health Conditions

Pneumonia (2 or more times within past 12 months) – including Aspiration Pneumonia **(PNEUM)**

◯ Never present ◯ History of condition, but not treated for the condition within the past 12 months
◯ Treated for the condition within the past 12 months ◯ Information unavailable

Asthma (ASTHMA)

◯ Never present ◯ History of condition, but not treated for the condition within the past 12 months
◯ Treated for the condition within the past 12 months ◯ Information unavailable

Upper Respiratory Infections (3 or more times within past 12 months) **(RESP)**

- ◯ Never present
- ◯ History of condition, but not treated for the condition within the past 12 months
- ◯ Treated for the condition within the past 12 months
- ◯ Information unavailable

Gastroesophageal Reflux, or GERD (GERD)

- ◯ Never present
- ◯ History of condition, but not treated for the condition within the past 12 months
- ◯ Treated for the condition within the past 12 months
- ◯ Information unavailable

Chronic Bowel Impactions (BOWEL)

- ◯ Never present
- ◯ History of condition, but not treated for the condition within the past 12 months
- ◯ Treated for the condition within the past 12 months
- ◯ Information unavailable

Seizure disorder or Epilepsy (SEIZURE)

- ◯ Never present
- ◯ History of condition, but not treated for the condition within the past 12 months
- ◯ Treated for the condition within the past 12 months and seizure free
- ◯ Treated for the condition within the past 12 months, but still experience occasional seizures (less than one per month)
- ◯ Treated for the condition within the past 12 months, but still experience frequent seizures
- ◯ Information unavailable

Progressive neurological disease, e.g., Alzheimer's (NEURO)

- ◯ Not present
- ◯ Treated for the condition within the past 12 months
- ◯ Information unavailable

Diabetes (DIABETES)

- ◯ Never present
- ◯ History of condition, but not treated for the condition within the past 12 months
- ◯ Treated for the condition within the past 12 months
- ◯ Information unavailable

Hypertension (HYPERTEN)

- ◯ Never present
- ◯ History of condition, but not treated for the condition within the past 12 months
- ◯ Treated for condition within the past 12 months and blood pressure is stable
- ◯ Treated for condition within the past 12 months, but blood pressure remains high or unstable
- ◯ Information is unavailable

Obesity (OBESITY)

- ◯ Not present
- ◯ Medical diagnosis of obesity or 30 pounds overweight

_____ _____

Name **Date**

Customer Name: _____

WMU/Behavioral Health Services - COMMUNICABLE DISEASE RISK SCREEN

People who report a history of substance use are at a greater risk for developing certain serious communicable diseases. Please answer the following questions to determine if you may need further health assessment.

The following questions relate to HIV (the virus that causes AIDS), Hepatitis A, B and/or C, Sexually Transmitted Infections (STIs), e.g., Herpes, Gonorrhea, Syphilis, Chlamydia, and Tuberculosis (TB).

I. To be completed by Customer:

A. Needle Use:

1. When was the last time, if ever, that you used a needle to inject drugs or medication; please include medication prescribed by a doctor (please check box):

☐ Within the past 2 days

☐ 3 to 7 days ago

☐ 1 to 4 weeks ago

☐ 1 to 3 months ago

☐ 4 to 12 months ago

☐ More than 12 months ago

☐ Never (skip to Section B)

2. During the past 12 months, did you…
   a. Use a needle to inject drugs? ☐ Yes ☐ No
   b. Reuse a needle that you had used before? ☐ Yes ☐ No
   c. Reuse a needle without cleaning it w/ bleach or boiling water first? ☐ Yes ☐ No
   d. Use a needle that you knew or suspected someone else had used before?
      ☐ Yes ☐ No
   e. Use someone else's rinse water, cooker or cotton after they did? ☐ Yes ☐ No
   f. Skip cleaning your needle with bleach or boiling water after you were done?
      ☐ Yes ☐ No
   g. Let someone else use a needle after you used it? ☐ Yes ☐ No
   h. Let someone use the rinse water, cooker or cotton after you did? ☐ Yes ☐ No
   i. Allow someone to inject you with drugs? ☐ Yes ☐ No
3. During the past 90 days, how many days did you use a needle to inject any kind of drug or medication? ___
4. During the past 90 days, how many people have you shared needles/works with? ___
5. During the past 90 days, on how many days did you share needles with other people? ___

B. Sexual Activity:

1. When was the last time, if ever, that you had any kind of sex (vaginal, oral, or anal) with another person? _____
2. During the past 12 months, did you…?
   a. Have sex while you or your partner was high on alcohol or other drugs?
      ☐ Yes ☐ No
   b. Have sex with someone who was an injection drug user? ☐ Yes ☐ No
   c. Have sex involving anal intercourse? ☐ Yes ☐ No
   d. Have sex with a man who might have had sex with other men? ☐ Yes ☐ No
   e. Have sex with someone who you thought might have HIV or AIDS?
      ☐ Yes ☐ No
   f. Have two or more different sex partners (not necessarily at the same time)?
      ☐ Yes ☐ No
   g. Have sex with a male partner? ☐ Yes ☐ No
   h. Have sex with a female partner? ☐ Yes ☐ No
   i. Have sex without using any kind of condom, dental dam, or other barrier to protect you and your partner from diseases or pregnancy? ☐ Yes ☐ No
   j. Have a lot of pain during sex or after having had sex? ☐ Yes ☐ No
   k. Use alcohol or other drugs to make sex last longer or hurt less? ☐ Yes ☐ No

C. Exposure:

1. When was the last time, if ever, that you were exposed to another person's blood and/or body fluids? _____
2. When was the last time, if ever, that you were tested for hepatitis? _____
3. When was the last time, if ever, that you had a positive TB skin test, TB blood test or chest x-ray? _____
4. Have you been in close contact with individuals diagnosed with TB within the last 30 days? ☐ Yes ☐ No
5. Have you had a nagging cough for more than three weeks along with any of the following symptoms:
   - Weight loss, fever for 3 days or longer? ☐ Yes ☐ No
   - Night sweats? ☐ Yes ☐ No
   - Coughing up blood? ☐ Yes ☐ No
   - Sudden and significant weight loss? ☐ Yes ☐ No
6. Have you recently lived in a substance use treatment facility, homeless shelter, drug house, mental health hospital, transitional living, jail, prison, or in other close quarters with people you did not know well? ☐ Yes ☐ No

If you answered "Yes" to ***any*** of the above questions you may be at risk for HIV, Hepatitis, sexually transmitted infections, or tuberculosis. You will be given information on how HIV, Hepatitis, STIs and TB are transmitted, and how substance use can put you at risk for contracting these diseases. You will also be provided ways to decrease the risk for getting these diseases or giving them to others.

II. To be completed by Treatment Program:

Customer is High Risk for Communicable Disease

☐ Yes ☐ No (client answered 'No' to all questions)

If at risk, please indicate referrals:

- ☐ Public Health Department (HIV/AIDS, TB, STI, Hepatitis testing):
- ☐ Private Physician Name:
- ☐ HIV/AIDS/STI/TB Hotline/Resources:
- ☐ Other Resources not Listed (specify):
- ☐ Provided Education:

Additional Comments:

_____

_____

I have reviewed the above information with the customer, provided basic education, and made referrals as outlined above.

_____ _____

Treatment Staff Signature Date

Agency staff have reviewed this form with me and have provided information, education, resources, and referrals for testing as necessary.

_____ _____

Customer Signature Date

RISK SCREENING REFERRAL GUIDE

The following are local resources or hotlines related to items identified on the Communicable Disease Risk Screen. The check marked resources can provide you with further information and services based on the results of your risk screening.

Testing/Treatment/Information/Support:

- ☐ AIDS Partnership Michigan …… 800-872-2437
- ☐ En Espanol …… 800-344-7432
- ☐ Cares Sexual Wellness
  - Benton Harbor …… 269-927-2437
  - Kalamazoo …….. 269-381-2437
- ☐ Michigan Department of Health and Human Services HIV Hotline …… 800-872-2437
- ☐ Teen AIDS Hotline …….. 800-232-4636
- ☐ Hepatitis C Association Support Hotline …… 877 HELP-4HEP
- ☐ Liver Health Connection …….. 800-522-HEPC
- ☐ National Sexually Transmitted Disease Hotline 800 232-4636

Health Departments:

- ☐ Barry County 269 945-9516
- ☐ Berrien County
  - Benton Harbor……...269 926-7121
  - Niles……269 684-2800
- ☐ Branch/Hillsdale/St. Joseph Counties
  - Coldwater……...517 279-9561
  - Hillsdale……..517 437-7395
  - Three Rivers……..269 273-2161
- ☐ Calhoun County
  - Albion……..517 629-9434
  - Battle Creek……...269 969-6370
- ☐ Kalamazoo County……...269 373-5203
- ☐ Van Buren/Cass Counties
  - Lawrence……269 621-3143
  - Dowagiac……269 782-0064