# Medi-Cal Mental Health Consumer Information Form

*Please complete prior to seeing your counselor or doctor.*
*You may leave any questions blank that you are not comfortable responding to in writing.*
*Respond for yourself, or for the person who will be receiving Mental Health Services. Thank you.*

| **Last Name** | **First Name** | **Middle Name** |
|---|---|---|
| **Name you wished to be called** | **Past Names** | |
| **Date of Birth** | **Gender (circle )** Male Female Intersex Other<br>Transgender: Male to Female or Female to Male | **Social Security Number** |
| **Medi-Cal Card Number** | **Highest School Grade Completed:** | |

**PRIMARY LANGUAGE**
*(Please check **only one**)*

- ☐ **A** English
- ☐ **B** Spanish
- ☐ **C** Chinese Dialect
- ☐ **D** Japanese
- ☐ **E** Tagalog
- ☐ **F** Vietnamese
- ☐ **G** Lao
- ☐ **H** Cambodian
- ☐ **I** ASL
- ☐ **J** Other Non-English
- ☐ **K** Cantonese
- ☐ **L** Korean
- ☐ **M** Mandarin
- ☐ **N** Armenian
- ☐ **O** IIocano
- ☐ **P** Mien
- ☐ **Q** Hmong
- ☐ **R** Turkish
- ☐ **S** Hebrew
- ☐ **T** French
- ☐ **U** Polish
- ☐ **V** Russian
- ☐ **W** Portuguese
- ☐ **X** Italian
- ☐ **Y** Arabic
- ☐ **Z** Samoan
- ☐ **1** Thai
- ☐ **2** Farsi
- ☐ **3** Other Sign
- ☐ **9** UNK/Not Reported

**PREFERRED LANGUAGE**
For Receiving MH Svs
*(Please check **only one**)*

- ☐ **A** English
- ☐ **B** Spanish
- ☐ **C** Chinese Dialect
- ☐ **D** Japanese
- ☐ **E** Tagalog
- ☐ **F** Vietnamese
- ☐ **G** Lao
- ☐ **H** Cambodian
- ☐ **I** ASL
- ☐ **J** Other Non-English
- ☐ **K** Cantonese
- ☐ **L** Korean
- ☐ **M** Mandarin
- ☐ **N** Armenian
- ☐ **O** IIocano
- ☐ **P** Mien
- ☐ **Q** Hmong
- ☐ **R** Turkish
- ☐ **S** Hebrew
- ☐ **T** French
- ☐ **U** Polish
- ☐ **V** Russian
- ☐ **W** Portuguese
- ☐ **X** Italian
- ☐ **Y** Arabic
- ☐ **Z** Samoan
- ☐ **1** Thai
- ☐ **2** Farsi
- ☐ **3** Other Sign
- ☐ **9** UNK/Not Reported

**PREFERRED WRITTEN LANGUAGE**
*(Please check **only one**)*

- ☐ **A** English
- ☐ **B** Spanish
- ☐ **C** Chinese Dialect
- ☐ **D** Japanese
- ☐ **E** Tagalog
- ☐ **F** Vietnamese
- ☐ **G** Lao
- ☐ **H** Cambodian
- ☐ **I** ASL
- ☐ **J** Other Non-English
- ☐ **K** Cantonese
- ☐ **L** Korean
- ☐ **M** Mandarin
- ☐ **N** Armenian
- ☐ **O** IIocano
- ☐ **P** Mien
- ☐ **Q** Hmong
- ☐ **R** Turkish
- ☐ **S** Hebrew
- ☐ **T** French
- ☐ **U** Polish
- ☐ **V** Russian
- ☐ **W** Portuguese
- ☐ **X** Italian
- ☐ **Y** Arabic
- ☐ **Z** Samoan
- ☐ **1** Thai
- ☐ **2** Farsi
- ☐ **3** Other Sign
- ☐ **9** UNK/Not Reported

**RACIAL BACKGROUND/ETHNICITY:**
*(Please select **up to five**)*

- ☐ **A** White/Caucasian
- ☐ **B** Black/African American
- ☐ **C** Amer. Indian or Alaska Native
- ☐ **D** Mexican American
- ☐ **E** Latin American
- ☐ **F** Other Spanish
- ☐ **G** Chinese
- ☐ **H** Vietnamese
- ☐ **I** Laotian
- ☐ **J** Cambodian
- ☐ **K** Japanese
- ☐ **L** Filipino
- ☐ **M** Other Asian
- ☐ **N** Other
- ☐ **P** Other Pacific Islander
- ☐ **Q** Korean
- ☐ **R** Samoan
- ☐ **S** Asian Indian
- ☐ **T** Native Hawaiian
- ☐ **U** Guamanian
- ☐ **V** Hmong
- ☐ **W** Mien
- ☐ **O** UNK/Not Reported

**LATINO/HISPANIC ORIGIN?**
☐ **Y**es ☐ **N**o ☐ **U**nknown

**RELATIONSHIP STATUS**

| | |
|---|---|
| ☐ **1** Nvr Married | ☐ Never Partnered |
| ☐ **2** Married | ☐ Partnered (P.) |
| ☐ **3** Widowed | ☐ Partner Deceased |
| ☐ **4** Divorced | ☐ Perm Sep from P. |
| ☐ **5** Separated | ☐ Temp Sep from P. |

| **Birthplace (County, State, Country)** | | |
|---|---|---|
| **Birth Mother's First Name** | **Birth Mother's Maiden Name** | **Birth Mother's Middle Name** |
| **Address (Street Name & Number)** | | |
| **City** | **State** | **ZIP Code** |
| **Telephone (primary)** | **Telephone (message)** | |

**Sexual Orientation (circle)**

Heterosexual/Straight, Lesbian, Gay, Bisexual , Queer, Questioning = Not sure , Unknown, Decline to state,

Other: _____, I don't know what this question is asking.

| **Emergency Contact Name** | **Relationship to you** | **Telephone Number** |
|---|---|---|
| | | |

**Emergency Contact Address (street name, city, state, ZIP Code)**

**Are you a Caregiver of dependents (at least 50% of the time)?** Yes No

List their ages: _____, _____, _____, _____, _____, _____, _____

**Who lives in your home (list first names, ages and relationship):**

| First Name | Age | Relationship |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## EDUCATION
## Child's Information

| **Name of School** | **Grade** | **Special Education: (circle)** Yes No |
|---|---|---|
| | | |

| **Teacher's Name:** | **Teacher's Telephone Number** |
|---|---|
| | |

## EMPLOYMENT

| Type of Job Held: | How long in field |
|---|---|
| 1) | |
| 2) | |
| 3) | |
| 4) | |

| **Who Referred you for Services:** | **Have you ever been arrested (circle)** Yes No |
|---|---|
| | |

**What problems are you now having (what brought you in for services today)?**

**What would you like to see improve in your life?**

**Circle any areas in which you are having problems (circle all that apply):**

Family School Work Food/Shelter Relationships Physical Health Drugs Alcohol

Taking care of myself Needing to be hospitalized Others: _____

**Circle symptoms you are having: (circle all that apply)**

Poor Memory Thinking Problems Depression Anxiety or Panic Attacks Poor Attention Binging or Purging

Not Eating Mood Swings Destructive Thoughts Hearing or Seeing things that others do not see or hear

Others: _____

**Do you have thoughts of hurting yourself?** Yes No

**Do you have thoughts of hurting someone else?** Yes No

**Does your weight affect the way you feel about yourself?** Yes No

**Are you satisfied with your eating pattern?** Yes No

**Have you ever been in a relationship with someone who has hit, kicked, slapped, punched or threatened to hurt you?**
**Currently:** Yes No **In the past:** Yes No

**Are you in a relationship with someone who yells at you, calls you names or puts you down?** Yes No

**List ALL medications you are taking, both over the counter and prescribed:**

| ***Name of Medication :*** | ***Dosage:*** | ***MD:*** | ***Date 1st prescribed:*** | ***When last taken:*** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**List ALL psychiatric medications you have taken in the past:**

| | |
|---|---|
| | |
| | |
| | |

**Have you ever been hospitalized? (If yes: when and where)?** Yes No

| **Date** | **Hospital Name and Location (City and State)** |
|---|---|
| | |
| | |
| | |

**Your Doctors (name and telephone number):**

| **Name of Primary Care Provider:** | **Telephone Number:** |
|---|---|
| **Name of Psychiatrist:** | **Telephone Number:** |

| **Date of your last health physical:** | **Date of your last Dental appointment:** |
|---|---|

**Circle any medical problems you have had, or now have:**

| | | |
|---|---|---|
| Allergies | Arterial Sclerosis | Arthritis |
| Asthma | Birth Defects | Visual Problems |
| Cancer | Carpal Tunnel Syndrome | Pain Problems |
| Liver Problems | Cystic Fibrosis | Deaf/Hearing Impaired |
| Diabetes | Digestive Problems | Ear Infections |
| Heart Problems | Hepatitis/Liver Problems | Cholesterol Problems |
| Thyroid Problems | Kidney Problems | Headaches |
| Multiple Sclerosis | Muscular Dystrophy | Appetite or Weight Problems |
| Osteoporosis | Parkinson's Disease | Physical Disability |
| Artificial Limbs | Skin Problems | Sexually Transmitted Diseases |
| Stroke | Ringing in the Ears | Stomach Problems |
| Sleep Problems | Tuberculosis (TB) | Urinary Problems |
| Loss of Consciousness | Exposed to Toxic Lead | Fertility Problems |
| Pregnant | Head Injuries | Blood Pressure Problems |

**List all Allergies (include allergies to medications):**

## ALCHOL/DRUG USE

**Circle True or False:**

| | | |
|---|---|---|
| Drinking or drug use sometimes causes me to miss school, work, or important appointments: | True | False |
| I sometimes drink or use drugs when it is dangerous to do so: | True | False |
| I sometimes have problems with the police (or school teacher or principal) due to my drinking or drug use: | True | False |
| I sometimes drink or use drugs even though they cause me problems in life: | True | False |
| I need more now to get drunk, or high, than I used to: | True | False |
| Trying to quit makes me sick: I get withdrawal symptoms: | True | False |
| I sometimes end up drinking or using more than I meant to: | True | False |
| I have tried to quit before, but failed: | True | False |
| I spend more and more time getting and using drugs/alcohol: | True | False |
| I sometimes choose drugs or alcohol over friends and family: | True | False |
| I keep using even though the drug/alcohol makes me sick or messes with my mind: | True | False |

**Circle ALL that you have tried:**

| | |
|---|---|
| Alcohol | Amphetamines: Speed/Uppers/Crank/Ritalin |
| Cocaine/Crack | Opiates: Heroin/Opium/Methadone |
| Hallucinogens: LSD/Mushroom, Peyote, Ecstasy | Marijuana |
| Sleeping Pills/Pain Killers/Valium or Similar | Hashish |
| PCP or Designer drugs/GHB | Cigarettes |
| Inhalants: Paint/Gas/Glue/Spray cans | Other Tobacco: Chewing/Etc. |

Others: _____

**Have you ever been referred to a drug or alcohol treatment program: (if yes, list)** Yes No

**Name of Program(s):**

**1)**

**2)**

**3)**

**Please tell us anything else you would like us to know.**