



OC Use Only:

Arrive:

Intake:

Welcome to ComWell!

We want to start by thanking you for coming to ComWell. We hope this is a great first step to having a better life. To begin services, we need to know more about you and why you are here. We want to make sure you get the most from your visit. Please let the Office Coordinator know if you have any questions or concerns.

Have you been to ComWell before?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know		
First Name:		Date of Birth:		
Middle Name:		Social Security Number:		
Last Name:		Suffix (Jr, Sr):		
Address:				
City:		Zip:		
Email:				
Phone:		Can we text you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Race:		Would you want to see a counselor online?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ethnicity:		Preferred Language:		
Gender:		Gender Identity:		
What is your Marital Status:		What is your Religious Preference:		
Primary Care Physician:		Physician Number:		
Guardianship Status:	<input type="checkbox"/> Own Guardian <input type="checkbox"/> Biological Parent <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Other			
What is the highest level of Education you have attained?				
What is your current Living Arrangement?	<input type="checkbox"/> I live alone <input type="checkbox"/> I live with my parent/guardian or other relatives <input type="checkbox"/> I live in a foster home <input type="checkbox"/> I currently do not have a permanent residence			
What is your Employment Status? Check all that apply:	<input type="checkbox"/> Full <input type="checkbox"/> Part <input type="checkbox"/> Homemaker <input type="checkbox"/> Military <input type="checkbox"/> Retired <input type="checkbox"/> Self-Employed <input type="checkbox"/> Student <input type="checkbox"/> Unable to Work <input type="checkbox"/> Unemployed			
Emergency Contact – In case we cannot reach you.				
Name:				
Relationship to you:		Phone:		

Please tell us what brought you in today: _____

Please continue on other side

Please place a check next to any of the statements that are true for you:

<input type="checkbox"/> I am feeling more anxious than usual.	<input type="checkbox"/> I have lost interest in things I used to like.
<input type="checkbox"/> I need some help getting back on track.	<input type="checkbox"/> I feel more depressed than normal.
<input type="checkbox"/> I have had thoughts of suicide in the last 7 days.	<input type="checkbox"/> I have had thoughts of suicide in the last 24 hours.
<input type="checkbox"/> I have been drinking more than I used to.	<input type="checkbox"/> I need help getting clean or staying clean.
<input type="checkbox"/> I have been using IV drugs.	<input type="checkbox"/> My child(ren)'s behavior is a problem.
<input type="checkbox"/> I am having problems in my relationships.	<input type="checkbox"/> I am about to get evicted.
<input type="checkbox"/> I have been in trouble with the law.	<input type="checkbox"/> I was recently in a psychiatric hospital.
<input type="checkbox"/> I was recently in an inpatient substance use facility.	<input type="checkbox"/> I am having difficulty keeping my thoughts straight.
<input type="checkbox"/> Someone close to me recently died.	<input type="checkbox"/> I have trouble shutting my mind down.
<input type="checkbox"/> I have more trouble sleeping than usual.	<input type="checkbox"/> I have previously been given a diagnosis.
<input type="checkbox"/> I want to talk about something bad that happened to me.	<input type="checkbox"/> I have received counseling in the past.
<input type="checkbox"/> I am currently pregnant or think I might be pregnant.	<input type="checkbox"/> I have children under the age of 18 that live with me.
If you have received counseling in the past, did you have a good experience?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
I am related to someone that works at ComWell.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

At ComWell we want our offices to have convenient hours. When would your ideal appointment be?

<u>First Choice – Office Location, Day and Time:</u>	<u>Second Choice – Office Location, Day and Time:</u>

Finally, we have a few more questions that will help us better serve you:

Are you a parent of children under the age of 18?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently, or have you ever served, in the military?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is someone in your immediate family now, or previously, active military?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has someone referred you to us? <i>Examples: Primary Care Doctor, DCFS, TANF, TASC, Court, Probation, Inpatient Facility, Friend/Family, School</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, please indicate who: _____		
Please list any/all medications (including over the counter medications, herbal and vitamins) you are taking:		
Additionally, the following two questions to help us understand if you are eligible for reduced-fee or even free services based on your household size and income.		
How many people are in your household?		
What is the Estimated Monthly Income for your household?		
Office Use Only:		
Insurance Type (check all that apply)		
<input type="checkbox"/> Private Insurance/Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Fee for Service or <input type="checkbox"/> MCO <input type="checkbox"/> None/Private Pay <input type="checkbox"/> Unknown		
Guardian Consent Received for Services: <input type="checkbox"/> Yes <input type="checkbox"/> No		