TriCity Family Services

CLIENT APPLICATION

General Info

Client Name: _____ Date: _____

Address: _____ Home #: (____)_____ Cell #: (____)_____

City, State, Zip: _____ Work #: _____

Present Household / Family

Options: Married, Single, Co-habiting, Separated, Divorced, Widowed

Options: White, African American, Hispanic, Native American, Asian, Other

Full Name (no nicknames)	Birth Date Mo / Day / Yr	Relationship to You	Marital Status	Education Level	Race / Ethnicity	Living at home? (Yes or No)
CLIENT NAME HERE		self				

If client is under the age of 18, please provide mother's maiden name: _____

May we call to remind you of upcoming appointments? ☐ Yes ☐ No
If yes, at what telephone number? (_____)_____

Personal Profile

◦ Do you speak English? ☐ Yes ☐ No If no, what language do you speak? _____

Emergency Contact Person: _____
Address: _____
_____
Phone #: _____

Child under DCFS Guardianship: _____
Foster Parents: _____
Address: _____
_____
Phone #: _____

IDCFS Case Worker: _____
Address: _____
_____
Phone #: _____

PLEASE COMPLETE REVERSE SIDE ⇒

Please complete the following information if you will be using commercial insurance, ALL KIDS or wish to apply for our sliding fee scale. If you do not wish to complete this information, you will be responsible for paying the full fee.

Income #1 (Yourself)

Annual Gross Income $_____

Income #2 (Spouse/Partner)

Annual Gross Income $_____

Additional income

Such as part time employment, second job, public aid, unemployment, child support, interest, other:

Type: _____ Annual Total: $_____

Type: _____ Annual Total: $_____

TOTAL ANNUAL HOUSEHOLD INCOME: $_____

FOR OFFICE USE ONLY

Attestation of Consumer Monthly Income

Consumer Name: _____
Last First Middle

RIN: _____ Household Size: _____ persons

Gross Monthly Household Income: $_____

Source: _____

D = Document (pay stub, tax form, etc.)
C = Consumer attestation
G = Consumer parent or guardian attestation
P = Provider attestation

Signature: _____ Date: _____

A. Have you sought help in obtaining any of the following services:

- ☐ Substance Abuse Treatment
- ☐ MH Case Management
- ☐ Hospitalization
- ☐ Other _____
- ☐ Unknown
- ☐ Not Applicable
- ☐ Residential/Living Arrangements
- ☐ Vocational Rehabilitation
- ☐ Transportation
- ☐ Medical

B. Please file claims to my insurance company according to the information I have provided below:

Employee _____

Soc. Security # and/or ID# _____Group #_____

Name of Insurance Company _____

Insurance Company Phone # _____

Insurance Company Address _____

City: _____ State: _____ Zip: _____

The insured or authorized person's signature is required if you are using your insurance benefits for:

1. The release of any medical or other information necessary to process this claim.
2. The payment of medical benefits to TriCity Family Services who accepts assignment for its services.

SIGNED _____ DATE _____

C. Please answer the following questions:

1. If the client is under 18, do they currently have an ALL KIDS Card? ☐ Yes ☐ No
   If yes, what is the ALL KIDS Number: _____
2. Are you currently enrolled in Medicare? ☐ Yes ☐ No
   If yes, what is your Medicare Number: _____
3. Are you currently applying for or receiving SSI/SSDI?
   ☐ Yes ☐ No
4. Are you currently enrolled in CILA, ACT, DFI? ☐ Yes ☐ No

Please attach a copy of your Insurance / ALL KIDS / Medicare card

TriCity Family Services

Symptom Checklist

Please complete for each person attending the first appointment.

Client's Name: _____ Date: _____

Person Completing Form: _____

Please check how often these symptoms occurred *in the last 6 months.* If you are a parent completing this form for your child/adolescent, please provide your child's/adolescent's symptoms *in the last six months.*

SYMPTOM	Never or rarely	A few times a month	Nearly every day	SYMPTOM	Never or rarely	A few times a month	Nearly every day
Guilt Feelings				Hopeless about future			
Worrying				Thinking about death			
Too much energy				Thinking about suicide			
Aggressive				Problems with family members			
Uncontrolled temper				Brooding about the past			
Afraid of work/school				Crying excessively			
Afraid of leaving house				Feeling down or sad			
Sleep walking				Nightmares			
Problems falling asleep				Feeling anxious			
Problems staying asleep				Feeling panicky			
Memory loss				Problems with anger			
Trouble making decisions				Feeling jealous			
Feeling alone				Feeling impatient			
Difficulty concentrating				No confidence in self			
Sudden mood changes				Shortness of breath			
Restlessness				Fast heart beat			
Easily Distracted				Chest pains			
Problems getting along				Feelings of unreality			
Feeling worthless				Lying			
Overly tired				Problems at home			
Poor or no appetite				Alcohol use			
Over eating				Drug use			
Bingeing				Blackouts			
Food preoccupation				Stomach Problems			
Vomiting				Uncontrolled thoughts			
Sleeping too much				Uncontrolled behavior			
Hearing voices				Physical abuse of self or others			
Problems at work/school				Emotional abuse of self or others			
Stealing				Other:			

TriCity Family Services

CLIENT HISTORY
Counseling Program

Name: _____ Date: _____

What concern(s) brings you to Counseling?

_____

_____

_____

What changes do you want to see as a result of coming to Counseling?

_____

_____

_____

Client's Medical History

Currently under a doctor's care: _____**Yes** _____**No**

Doctor(s) involved in your care: _____

Health problems (include allergies): _____

Medication currently used: None

Medication	Dosage	Doctor Prescribing	Why Prescribed

Past Hospitalizations - Medical, Psychiatric, Chemical Dependency: None

Date (s)	Reason (s)	Hospital

Previous Counseling, EAP or Chemical Dependency Services: None

Facility/Counselor Name	Date (s)	Reason (s)	Helpful?