COUNTY OF SAN LUIS OBISPO HEALTH AGENCY
BEHAVIORAL HEALTH DEPARTMENT
Nicolas Drews, *Health Agency Director*
Star Graber, LMFT *Behavioral Health Director*

You have been referred to County of San Luis Obispo's Youth Substance Use Program. Please fill out the attached documents and then call 805-781-4754 or email BH.youthsudreferral@co.slo.ca.us and a staff member will schedule you to complete your screening session in person.

Both the guardian and the youth need to sign the documents. If you have MediCal/CenCal insurance the service will be billed at no cost to you, if you have other (private) insurance this service is paid by for the school district.

The location of your appointment:
805 4th St.
Paso Robles, CA 93446
*2nd Floor / 805-237-7070

Thank you and if you have any questions, please reach out to the number above or email us,

County of San Luis Obispo
Behavioral Health
Youth Substance Use Program

County of San Luis Obispo Behavioral Health

Client Information

Client MR#: _____ Social Security Number: _____

Prefix ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms.

Client Name: _____
(First) (Middle) (Last)

Email: _____

Medicaid ID: _____ Medicare Beneficiary ID: _____

Phone Number #1: _____ Type: ☐ Home ☐ Cell ☐ Business ☐ Other
☐ Do Not Call ☐ Do Not Leave a Message

Phone Number #2: _____ Type: ☐ Home ☐ Cell ☐ Business ☐ Other
☐ Do Not Call ☐ Do Not Leave a Message

Street Address: _____ City/State/Zip Code: _____
Billing Address: ☐ Yes ☐ No If no, billing address: _____

Comments: List any special needs or considerations important to note about the client.

Client Aliases

Client Name: _____
(First) (Middle) (Last)
Type: ☐ Nickname ☐ Preferred Name ☐ Former Name ☐ Alias

Client Name: _____
(First) (Middle) (Last)
Type: ☐ Nickname ☐ Preferred Name ☐ Former Name ☐ Alias

Client Name: _____
(First) (Middle) (Last)
Type: ☐ Nickname ☐ Preferred Name ☐ Former Name ☐ Alias

County of San Luis Obispo Behavioral Health

Client Information

Demographics

Date of Birth: _____ Sex: ☐ Male ☐ Female ☐ Not Listed

Marital Status:

☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Widowed
☐ Never Married ☐ Unknown

Gender Identity:

☐ Male ☐ Female ☐ Non-Binary ☐ Unsure/Questioning ☐ Other ☐ Transgender
☐ Female-to-Male (FTM)/Transgender Male/Trans Man ☐ Prefer not to answer
☐ Male-to-Female (MTF)/Transgender Female/Trans Woman ☐ Unknown/Not Asked
☐ Genderqueer, neither exclusively male nor female

Sexual Orientation:

☐ Heterosexual / Straight ☐ Lesbian (female) ☐ Gay (male) ☐ Bisexual ☐ Transgender
☐ Prefer not to answer ☐ Unsure / Questioning ☐ Declined to state ☐ Unknown/Not Asked

Pronoun: ☐ He ☐ She ☐ They ☐ Ze

Ethnicity:

☐ Amerasian ☐ American Native ☐ Asian Indian ☐ Black ☐ Cambodian ☐ Chinese
☐ Dominican ☐ Filipino ☐ Guamanian ☐ Hawaiian Native ☐ Hispanic/Latino ☐ Japanese
☐ Korean ☐ Laotian ☐ Mexican/Mexican American ☐ Multiple ☐ Not Hispanic or Latino
☐ Other Asian or Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ Unknown

Race:

☐ Alaskan native ☐ American Indian ☐ Asian Indian ☐ Black/African American
☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian ☐ Hmong ☐ Japanese ☐ Korean
☐ Laotian ☐ Mien ☐ Multiracial ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander
☐ Samoan ☐ Vietnamese ☐ White/Caucasian ☐ Unknown ☐ Prefer not to answer

Primary Care Physician: _____

☐ Client does not have PCP

Financial Information

Financially Responsible: ☐ Yes ☐ No

Annual Household Income: $_____ # of Dependents: _____# in Household: _____

Source of Income:
☐ Wages/Salary ☐ Public Assistance ☐ Retirement/Pension ☐ Disability
☐ Other ☐ None ☐ Unknown ☐ Not collected

Living Arrangements:

☐ Dependent Living ☐ Homeless ☐ Independent Living ☐ Private residence – Independent
☐ On the streets or in a homeless shelter ☐ Private residence – Dependent ☐ Adult or child
☐ Jail or correctional facility ☐ Institutional setting ☐ 24-hour residential care
☐ House or apartment (includes trailers, hotels, dorms, barracks, etc.) ☐ Group Home
☐ House or apartment, requiring some support with daily living activities (adults only)
☐ House or apartment, requiring daily support and supervision (adults only)
☐ Supported housing (adults only) ☐ Foster Family Home ☐ Residential Treatment Center
☐ Community Treatment Facility ☐ Board and Care ☐ Mental Health Rehabilitation Center
☐ Adult Residential Facility, Social Rehabilitation Facility, Crisis Residential, Transitional Residential, Drug Facility, Alcohol Facility ☐ State Hospital ☐ Justice-related ☐ Other
☐ Inpatient Psychiatric Hospital, Inpatient Psychiatric Health Facility (PHF), or Veterans Affairs (VA) Hospital ☐ Homeless, no identifiable residence ☐ Unknown/Not Reported
☐ Skilled Nursing Facility/Intermediate Care Facility/Institution of Mental Disease

County of Residence: _____ County of Financial Responsibility: _____

Education/Employment:

Educational Status:
Currently Enrolled: ☐ Yes ☐ No Grade Level Enrolled: _____
Highest Grade Level Completed: _____ Able to Read/Write: ☐ Yes ☐ No
☐ Able to read and write ☐ Able to read but not write ☐ Able to write but not read

Military Status: ☐ Yes ☐ No Veteran Status: ☐ Yes ☐ No

County of San Luis Obispo Behavioral Health

Client Information

Employment Status:

☐ Employed Full Time ☐ Employed Part Time ☐ Unemployed Seeking Work
☐ Unemployed Not Seeking Work ☐ Supported/Transitional Employment
☐ Homemaker ☐ Student ☐ Retired ☐ Disabled Not in Workforce ☐ Ages 0-5
☐ Volunteer Worker ☐ Resident/Inmate of Institution ☐ Other: _____

Criminal Justice Involvement:

☐ Probation ☐ Dept of Corrections ☐ Dept of Youth Services Commitment
☐ Jail ☐ Parole ☐ Not involved

Language:

Primary/Preferred Language: _____

☐ Client Does not Speak English ☐ Interpreter Services Needed

Hispanic Origin:

☐ Puerto Rican ☐ Mexican ☐ Cuban ☐ Other Hispanic ☐ Not of Hispanic Origin
☐ Prefer Not to Answer ☐ Unknown

Transportation Information

☐ Transportation Services Needed

Note any special needs accommodations (e.g. wheelchair, service animal, high rise)

Preferences

Communication Preference: ☐ Text Message ☐ Email ☐ Voice ☐ Do Not Send Any Notifications

Communication Phone Number: _____

Days of the week: ☐ Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri

Contacts

Contact #1 Information: Relationship: _____

Name _____ Date of Birth: _____
First Last

Email Address: _____ Organization: _____

☐ Financially Responsible ☐ Emergency Contact ☐ Guardian ☐ Household Member

☐ Care Team Member ☐ Healthcare Decision Maker

Phone #1: _____ Phone #2: _____

Address: ☐ Same as client

Street Address: _____

City, State, Zip: _____

Contact #2 Information: Relationship: _____

Name _____ Date of Birth: _____
First Last

Email Address: _____ Organization: _____

☐ Financially Responsible ☐ Emergency Contact ☐ Guardian ☐ Household Member

☐ Care Team Member ☐ Healthcare Decision Maker

Phone #1: _____ Phone #2: _____

Address: ☐ Same as client

Street Address: _____

City, State, Zip: _____

Contact #3 Information: Relationship: _____

Name _____ Date of Birth: _____
First Last

Email Address: _____ Organization: _____

☐ Financially Responsible ☐ Emergency Contact ☐ Guardian ☐ Household Member

☐ Care Team Member ☐ Healthcare Decision Maker

Phone #1: _____ Phone #2: _____

Address: ☐ Same as client

Street Address: _____

City, State, Zip: _____

Contact #4 Information: Relationship: _____

Name _____ Date of Birth: _____
First Last

Email Address: _____ Organization: _____

☐ Financially Responsible ☐ Emergency Contact ☐ Guardian ☐ Household Member

☐ Care Team Member ☐ Healthcare Decision Maker

Phone #1: _____ Phone #2: _____

Address: ☐ Same as client

Street Address: _____

City, State, Zip: _____

BEHAVIORAL HEALTH-HEALTH QUESTIONNAIRE

San Luis Obispo Behavioral Health Department	☐ DAS 2180 Johnson Ave, San Luis Obispo, CA 93401 Phone: (805) 781-4275 FAX (805) 781-1227	☐ MH 2178 Johnson Ave, San Luis Obispo, CA 93401 Phone: (800) 838-1381 FAX (805) 781-1177

Medical Providers:

Check any of the providers listed below you currently receive services from or have received from in the last 5 years.

☐Community Health Center ☐Private Community Physician ☐Hospital Emergency Rooms
☐Urgent Care Center ☐Pain Management Services ☐Specialty Medicine (i.e., Neurology, Cardiology, Endocrinology)
☐Dentists ☐Methadone Clinics

General Health Information

1. Date you last saw a Doctor / Nurse Practitioner / Physician Assistant:	2. What was the purpose of the visit?	3. Date of your last physical exam?

4. ☐ How many times have you visited an Emergency Room in the past 30 days?
5. ☐ How many days in past 30 have you stayed overnight in a hospital for physical health problems?
6. ☐ How many days in the past 30 have you experienced physical health problems?
7. ☐Yes ☐No Have you ever had surgery? If yes, please list:
8. ☐Yes ☐No Any other illness that requires frequent medical attention? If yes, please give details:

Allergies

9. ☐Yes ☐No Do you have any allergies? If yes, *what type of reaction did you have?* Fill out below-↓

Medication Allergies -

Food Allergies -

Other Allergies -

Medications

10. Please list any prescribed medications and over-the-counter medications you take regularly. (Include dosage and prescribing physician)

MEDICATION NAME	DOSAGE	FREQUENCY	PRESCRIBING PHYSICIAN

11. Which Pharmacy do you use?

12. Are you currently experiencing or do you have any of the following?

Yes	No		Yes	No	
☐	☐	Swollen Ankles	☐	☐	Seizures
☐	☐	Jaundice	☐	☐	Headaches
☐	☐	Sinus Problems	☐	☐	Weight Gain or Loss Recently
☐	☐	Bleeding Problems - Bruising Easily	☐	☐	Shortness of Breath
☐	☐	Joint Pain or Stiffness	☐	☐	Blood Transfusions
☐	☐	Difficulty Swallowing	☐	☐	Arthritis
☐	☐	Chest Pain (Angina)	☐	☐	Stroke - If yes, give details: _____
☐	☐	Excessive Heartburn or Abdominal Pains	☐	☐	High Blood Pressure
☐	☐	Excessive Thirst	☐	☐	Low Blood Pressure
☐	☐	Cough, Persistent or Bloody	☐	☐	Artificial Joint
☐	☐	Chronic Back Pain	☐	☐	Head Injury - If yes, give details: details: _____
☐	☐	Tooth or Gum Problems	☐	☐	Cancer
☐	☐	Nausea or Vomiting	☐	☐	Chemotherapy/Radiation
☐	☐	Diarrhea, Constipation, Blood in Stools	☐	☐	Diabetes
☐	☐	Dizziness or fainting	☐	☐	Asthma, Emphysema, or Chronic Bronchitis
☐	☐	Frequent or Bloody Urination	☐	☐	Anemia
☐	☐	Rashes	☐	☐	Heart Attack or Heart Problem - If yes, please give details:
☐	☐	Blurred or Double Vision			
☐	☐	Fever			

CLIENT NAME	CLIENT NUMBER

13. Women Only

Yes No

☐ ☐ Are you pregnant? If yes, due date: _____

☐ ☐ Are you breastfeeding? If yes, date of delivery: _____

☐ ☐ Have you had any miscarriages or abortions? If yes, please give details: _____

☐ ☐ Do you have difficult periods? If yes, please give details: _____

At what age did you start your first period? _____

Date of last period: _____

Yes No

☐ ☐ Have you experienced any domestic violence?

☐ ☐ Do you have pain with intercourse?

☐ ☐ Have you had an abnormal mammogram or lump? If yes, please give details: _____

☐ ☐ Have you had an abnormal PAP smear? If yes, please give details: _____

Date of last GYN exam: _____

Communicable Diseases

14. ☐Yes ☐No Have you ever been tested for TB? (Tuberculosis)?

15. ☐Yes ☐No Have you ever had a positive TB Test? Date of last TB Test or last chest X-ray: _____

16. ☐Yes ☐No Have you been diagnosed with Hepatitis C? Date of last test: _____

17. ☐Yes ☐No Have you been tested for any other liver disease?

18. ☐Yes ☐No Have you been diagnosed with a Sexually Transmitted Disease (STD)?

19. ☐Yes ☐No Did you get treated?

Date of last STD Test?

20. ☐Yes ☐No Have you been tested for HIV?

21. ☐Yes ☐No Did you receive the test result?

Date of last HIV Test?

Mental Health

22. ☐Yes ☐No Have you ever been diagnosed with a mental illness? If yes, what was your diagnosis? _____

23. ☐Yes ☐No Did you receive treatment? If yes, please give details:

24. ☐ How many times in the last 30 days have you received outpatient emergency services for mental health needs?

25. ☐ How many days in the last 30 have you stayed 24 hours or more in a hospital or psychiatric health facility for mental health needs?

26. ☐Yes ☐No In the past 30 days have you taken prescribed medication for mental health needs, including medication for anxiety?

27. ☐Yes ☐No Past suicide attempts?

28. Date of last suicide attempt:

29. How many suicide attempts in your lifetime?

Alcohol and Other Drugs

30. **Do you use the following substances and how frequently:**	**Daily**	**Often**	**Sometimes**	**Date last used**
Alcohol→				
Other substances→				

31. ☐Yes ☐No Have you ever injected drugs?

32. ☐Yes ☐No Have you shared needles?

33. ☐Yes ☐No Have you shared cottons?

34. ☐ How many days in the past 30 have you injected drugs?

Last time injected drugs:

35. ☐Yes ☐No Have you ever used SLO Co. Needle Exchange?

36. ☐Yes ☐No Are you in withdrawal today? If yes, list from what substance(s)?

37. ☐Yes ☐No Seizures, delirium tremens? If yes, please give details:

38. ☐Yes ☐No Have you had blackouts? If yes, please give details:

39. ☐Yes ☐No Are you currently smoking / ingesting marijuana? →

☐Yes ☐No Medical Marijuana Card?

Date last smoked/ingested marijuana:

40. ☐Yes ☐No Have you ever overdosed on alcohol or other drugs?

If Yes, please give details:

41. ☐Yes ☐No Do you currently use any tobacco products (cigarettes, electronic cigarettes, chew)?

To the best of my knowledge the above information is accurate and true, and I will inform my provider of changes in my health or medications:

Client Signature: **Date:**

Staff Signature: **Date:**

CLIENT NAME **CLIENT NUMBER**

COUNTY OF SAN LUIS OBISPO HEALTH AGENCY
BEHAVIORAL HEALTH DEPARTMENT

CLIENT COST EXPLANATION AND AGREEMENT

Your provider will explain the cost of services to you. In some cases, you must pay a reasonable fee for the services you receive. Contact your provider or the Billing office at (805) 781-4702 right away if:

- You are unable to pay your fee
- Your income/the number of people dependent on your income change
- You get (or lose) private insurance
- **You get (or lose) Medi-Cal**

☐ **Full Scope Medi-Cal (May include Medi-Medi)**
We accept Full Scope Medi-Cal as payment in full if **you remain eligible**. If you lose your Medi-Cal, you must pay for your services. Please let your provider know as soon as possible so we can help you regain your Medi-Cal or set fees.

☐ **Other Funding Sources (8500)**
County Referrals: AB109, Probation, Superior Court, Department of Social Services (DSS), Child Welfare Services, Family Treatment Court, Youth Treatment Services, School Referrals and Driving Under the Influence (DUI) Program Referrals. Drug and Alcohol Services receives grant money or is contracted by other agencies to provide services at no cost to you while you are enrolled in specific programs. If you also have Medi-Cal in San Luis Obispo, your Medi-Cal will be billed first.

☐ **Share of Cost (SOC) Medi-Cal (May include Medi-Medi)**
Some types of Medi-Cal have a monthly Share of Cost that you must pay before Medi-Cal covers the cost of treatment. The services you receive from every provider apply toward your Share of Cost. Call the Billing Office at 781-4702 to learn about how we help with your Share of Cost or talk to your Eligibility Technician at Department of Social Services to see if you qualify for full scope Medi-Cal, which has no Share of Cost.

Your monthly Share of Cost is: $_____

Client Name:_____ Client Number: _____

Annual period begins _____and ends: _____

My signature below confirms my understanding of the cost of services.

Client or Responsible
Person's Signature: _____ Date: _____

Staff Witness Signature: _____ Date: _____