Welcome to Health Service Alliance

To help us to give you the best care, we at Health Service Alliance (HSA) need to get to know you. We have four parts to this intake form: **SECTION 1** Please tell us about yourself; **SECTION 2** Please tell us your reason(s) for seeking help; **SECTION 3** Please tell us about your concerns and strengths; and **SECTION 4** Please tell us about your health history.

If you do not understand a question or need help filling out this form, please ask us for help.

SECTION 1: Please Tell Us About Yourself

1.A. Please tell us how to contact you:

Last Name _____ First Name _____ Preferred Name _____ ☐ Mr. ☐ Mrs. ☐ Ms. Preferred Prefix

Street Address _____

City _____ State _____ Zip Code _____

E-Mail Address _____

Date of Birth __/__/____ Age _____ Social Security Number ___-___-____

	Call	Voicemail	Text
Home Phone _____	☐	☐	☐
Work Phone _____	☐	☐	☐
Other Phone _____	☐	☐	☐

1.B. Please tell us about your gender:

Please note that while HSA recognizes the existence of multiple gender identities, unfortunately insurances and other legal entities do not. Please be aware that the name and sex listed on your insurance card must be used on any paperwork regarding insurance, billing, and correspondence. If your preferred name, pronoun, or prefix (e.g., Mr., Ms., etc.) is different than what is listed on your insurance card, please let us know.

Do you self-identify as: ☐ Heterosexual ☐ Lesbian/Gay ☐ Bisexual ☐ Unsure ☐ Other:_____

	Male	Female	Intersex	Transgender	Fluid/GNC	Other
What is your gender?	☐	☐	☐	☐	☐	☐ _____
What is your current legal sex?	☐	☐	☐			
What was your sex at birth?	☐	☐	☐			

What is your preferred pronoun? ☐ He ☐ She ☐ Them ☐ Other_____

1.C. Please tell us about your current relationship status:

☐ Single ☐ Married ☐Partnered ☐ Separated ☐ Divorced ☐ Widowed ☐ Other:_____

1.D. Please tell us about your racial background: (*Please check all that apply*)

☐ Hispanic/Latino (*e.g., Mexican-American, Latin American, Central or South American, Spanish-American, etc.*)
☐ Asian (e.g., *Filipino, Japanese, Cambodian, Chinese, Korean, Taiwanese, Southeast Asian/Indian, etc.*)
☐ Pacific Islander (*e.g., Native Hawaiian, Guamanian, Samoan, Tongan etc.*)
☐ American Indian/Alaskan Native ☐ Black/African American ☐ White/Caucasian

1.E. Please tell us what language(s) you are most comfortable with:

	English	Spanish	Cantonese	Mandarin	Tagalog	Vietnamese	Other:_____
Speaking:	☐	☐	☐	☐	☐	☐	☐
Reading:	☐	☐	☐	☐	☐	☐	☐
Writing:	☐	☐	☐	☐	☐	☐	☐

NAME _____

1.F. Please tell us about your current work situation:

☐ Part-time ☐ Full-time ☐ Temporary work
☐ Unemployed, seeking work
☐ Unemployed, not seeking work
(*e.g., student, retired, disabled, unpaid caregiver, etc.*)

1.G. Please tell us about your U.S. military status:

☐ Active Duty ☐ Discharged ☐ Not applicable

If you need referral to the VA for resources, please provide a copy of your DD-214 Discharge Form.

1.H. Please tell us the highest level of school you completed:

☐ Less than Grade 12 ☐ High school diploma/GED ☐ Some college ☐ Associate Degree ☐ Bachelor's Degree
☐ Graduate Degree (*e.g., Masters, PhD, etc.*) ☐ Vocational certification ☐ Other:_____
☐ Need assistance with reading/writing for any reason.

1.I. Please tell us if you have ever spent two or more nights in a jail, prison, detention center, juvenile correctional facility, or similar institution:

☐ No ☐ Yes, within the past year ☐ Yes, more than a year ago ☐ On probation/parole ☐ I choose not to answer

1.J. Please tell us about your housing situation today: (*Please check all that apply*)

☐ I have housing ☐ I choose not to answer
☐ I am worried about losing my housing
☐ I do not have housing (*e.g., staying with others, in car, hotel, shelter, living outside on the street/park*)

1.K. Please tell us how many people you live with, *including yourself*:

☐ 1 ☐ 2-4 ☐ 5-7 ☐ 8-10 ☐ 11 or more

1.L. Please tell us about the family members you live with:

Name	Age	Relationship	Name	Age	Relationship

1.M. Please tell us the total monthly income for everyone living in your household: $_____
(*This will help determine if you are eligible for benefits.*)

1.N. Please tell us who to call in case of an emergency:

Last Name _____ First Name _____ Phone Number _____

E-Mail Address _____ Relationship to you _____

Please tell us who to call if you are sick and need assistance:

Last Name _____ First Name _____ Phone Number _____

E-Mail Address _____ Relationship to you _____

NAME _____

1.O. Please tell us about your medical insurance: ☐ I have no insurance

Name of Insurance _____ Policy Number _____

Name of Insurance _____ Policy Number _____

1.P. Please tell us how your medical decisions will be made:

☐ **I am an adult (18 years or older) and:**

- ☐ I make my own decisions.
- ☐ I make my own decisions and have a written form that says who can make my decisions if cannot; I have a copy or will bring a copy of this form.
- ☐ I am able to make decisions but allow my family to assist with decisions:
  Name: _____
- ☐ I am unable to make decisions and the Court has named someone to make my decisions:
  Name: _____
  Phone Number: _____
- ☐ Decision maker is unknown at this time.

☐ **I am a child (17 years or younger) and:**

☐ **I am able to make my own decisions because**:

- ☐ I have a court order and/or California ID which indicates I am emancipated and will provide a copy of this order or identification.
- ☐ I am 15 or older, do not live with my family, and provide for my own needs (self-sufficient minor).
- ☐ I am active military
- ☐ I am married or have been married
- ☐ I am 12 or older and seeking treatment for one or more of the following:
  - ☐ Pregnancy care or termination
  - ☐ Communicable diseases
  - ☐ Sexual assault/rape
  - ☐ Mental Health
  - ☐ Drug/Alcohol abuse

☐ **I am unable to make decisions. One of the following persons makes my decisions:**

- ☐ Parent (if divorced must provide custody order)
- ☐ Guardian, Foster Parent or County Social Worker (must have copy of court order).
  Name: _____
  Phone Number: _____
- ☐ Step-Parent (only if adopted by step-parent or has legal parent's permission)

SECTION 2: Please Tell Us Your Reason(s) for Seeking Help

2.A. What made you come into HSA for help today?

_____

_____

_____

2.B. What is your goal for care?

_____

_____

NAME _____

2.C. How did you learn about HSA? ☐ Community Event ☐ Paper/Magazine ☐ Radio/TV ☐ Internet ☐ Friend/Relative ☐ Other _____

☐ Referral, please tell us who referred you: _____ _____
Last Name First Name

_____ _____
Phone Number Relationship to you

SECTION 3: Please Tell Us About Your Concerns and Strengths

3.A. Basic Needs: In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? (*Please check all that apply*)

☐ Food ☐ Utilities ☐ Phone ☐ Housing
☐ Clothing ☐ Childcare ☐ Medicine or any healthcare (*e.g., dental, mental health, vision, etc.*)
☐ Other: ☐ I choose not to answer

3.B. Support: How often each week do you see or talk to people that you care about and feel close to? (*e.g., talking to friends on the phone, visiting friends/family, going to church/club meetings, etc.*)

☐ Less than once a week ☐ 1-2 times/week ☐ 3-4 times/week ☐ 5+ times/week ☐ I choose not to answer

3.C. Stress: Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much ☐ I choose not to answer

3.D. Transportation: Has lack of transportation kept you from work, meetings, medical appointments, or items needed for daily living?

☐ No
☐ Yes, it has kept me from medical appointments or getting my medications
☐ Yes, it has kept me from non-medical meetings, work, appointments, or getting things that I need

3.E. Mental Health: Have you had mental health treatment before? ☐ Yes ☐ No

If "Yes" please explain: _____

_____

_____

Have you ever experienced any of the following?

Depressed/anxious mood, sadness/crying most of the day, nearly every day? ☐ Yes ☐ No
Less interest or pleasure in all, or almost all, activities most of the day, nearly every day? ☐ Yes ☐ No
A change in sleep patterns? ☐ Yes ☐ No
Thoughts/attempts of hurting or killing myself or others? ☐ Yes ☐ No
Have you heard or seen things that other people don't hear or see? ☐ Yes ☐ No

If you marked "Yes" to any of these, when did it happen and what, if anything, did you do about it? _____

_____

_____

_____

NAME

3.F. Safety: Do you feel physically and emotionally safe where you currently live?

☐ Yes ☐ No ☐ Unsure ☐ I choose not to answer

3.G. Abuse: In the past year have you been afraid of your partner or ex-partner?

☐ Yes ☐ No ☐ Unsure ☐ I have not had a partner in the past year ☐ I choose not to answer

3.H. What do you view as your strengths at this point in life? _____

_____

_____

Please share any serious stressors or issues in your history which may be part of your concerns today:_____

_____

_____

SECTION 4: Please Tell Us About Your Health History

4.A. Please tell us if you have experienced or been told you have any of the following:

Anemia or Jaundice	☐ Yes ☐ No	Frequent Infection/Boils	☐ Yes ☐ No	Mumps	☐ Yes ☐ No
Appetite/weight changes	☐ Yes ☐ No	Headaches/Migraines	☐ Yes ☐ No	Numbness/ Tingling/Swelling	☐ Yes ☐ No
Arthritis/Rheumatism	☐ Yes ☐ No	Hearing Problems	☐ Yes ☐ No	Chronic Pain	☐ Yes ☐ No
Attention deficit	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pneumonia or Pleurisy	☐ Yes ☐ No
Autism	☐ Yes ☐ No	Hemorrhoids/Rectal Bleeding	☐ Yes ☐ No	Polio	☐ Yes ☐ No
Back pain/bursitis, sciatica, joint pain	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Poor Nutrition/Eating Habits	☐ Yes ☐ No
Unusual Bleeding	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Bone/joint disease	☐ Yes ☐ No	High/Low Blood Pressure	☐ Yes ☐ No	Sexually Active	☐ Yes ☐ No
Bowel/urination problems	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Breast lump/discharge	☐ Yes ☐ No	Hives or Eczema	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Broken bones	☐ Yes ☐ No	Influenza	☐ Yes ☐ No	Skin Problems	☐ Yes ☐ No
Caffeine use	☐ Yes ☐ No	Job-Related Injury	☐ Yes ☐ No	Sleeping Difficulties	☐ Yes ☐ No
Cancer/tumors	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Slow/Delayed Mental Abilities	☐ Yes ☐ No
Chest pain/palpitations	☐ Yes ☐ No	Lacerations/Extensive Cuts	☐ Yes ☐ No	Sprains or Dislocations	☐ Yes ☐ No
Chicken pox	☐ Yes ☐ No	Life-Threatening or Terminal Illness	☐ Yes ☐ No	Stomach Pain/ Heartburn	☐ Yes ☐ No
Concussion/head injury	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Constipation/diarrhea	☐ Yes ☐ No	Loss of Consciousness	☐ Yes ☐ No	Blood or Plasma Transfusions	☐ Yes ☐ No
Cough for 30+ days	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Vision Problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Frequent Coughs/ Colds/Sore Throats	☐ Yes ☐ No	Meningitis	☐ Yes ☐ No		

NAME

4.A. (continued)
Please tell us more if you marked "Yes" for any illness or health problem above: _____

4.B. If you have had any of the following treatments, please tell us the most recent date(s):

Hepatitis A vaccine:	___/___/___	Tetanus booster:	___/___/___	TB skin test:	___/___/___
Hepatitis B vaccine:	___/___/___	Syphilis-RPR test:	___/___/___	HIV test:	___/___/___
Pneumonia vaccine:	___/___/___	Pneumovax:	___/___/___	Eye exam:	___/___/___
Flu Vaccine:	___/___/___	PSA:	___/___/___	Dental exam:	___/___/___
Colonoscopy:	___/___/___	Mammogram:	___/___/___	Pap smear:	___/___/___
Chickenpox vaccine:	___/___/___	Polio vaccine:	___/___/___	HPV vaccine:	___/___/___
Diphtheria, Pertussis, Tetanus (DPT):	___/___/___	Measles, Mumps, Rubella (MMR):	___/___/___		

4.C. Please tell us about your substance use now and in the past:

Do you currently use tobacco in any form? ☐ Yes ☐ No
If "Yes" what type(s)? ☐ Cigarettes ☐ Cigars/Pipes ☐ E-cigarettes/Vapes ☐ Smokeless/Chew
How often each day? _____ How long have you used tobacco? _____

Have you previously used tobacco? ☐ Yes ☐ No
If "Yes" how often each day? _____ How long did you use? _____ When did you quit? _____

Do you currently drink alcohol? ☐ Yes ☐ No
If "Yes" how often each week?_____

Have you previously used alcohol? ☐ Yes ☐ No
If "Yes" how often each week?_____ How long did you use? _____ When did you quit? _____

Do you currently use marijuana in any form? ☐ Yes ☐ No
If "Yes" how often each week? _____

Have you previously used marijuana? ☐ Yes ☐ No
If "Yes" how often each week?_____ How long did you use? _____ When did you quit? _____

Do you currently use any other substances? ☐ Yes ☐ No
If "Yes" what types and how often? _____

Have you used other substances in the past? ☐ Yes ☐ No
If "Yes" what types, when, and how often? _____

Is there anything else we should know? _____

4.D. Please tell us if you are allergic to any of the following:

☐ Antibiotics/Mycins ☐ Aspirin/Codeine/Morphine ☐ Cosmetics ☐ Drugs
☐ Food ☐ Latex/tape ☐ Penicillin/sulfa ☐ Seasonal ☐ Tetanus
☐ Other (*Please specify*):_____

NAME

4.E. Please tell us about any medications you are taking:

Name of Medication	Strength/ Dose	Number of pills/ Schedule				Reason for Medication	Start Date	End Date
		AM	Noon	PM	Night			

4.F. What Pharmacy do you use? Name: _____ City: _____ Phone: _____

4.G. What hospital do you usually go to? _____

If you have been in a hospital, please tell us why and on what dates: _____

_____

_____

If you have had any surgeries, please list them and include dates: _____

_____

4.H. Who in your family has been ill due to the following? (*Please check all that apply*)

	Mother	Father	Grandparent	Daughter	Son	Sibling	Aunt/Uncle	Cousin	None
Alcohol abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other_____	☐	☐	☐	☐	☐	☐	☐	☐	☐

NAME

ACKNOWLEDGMENT

Please select an item below:

☐ I have filled out this form to the best of my ability and have no questions about this form.

☐ I have filled out this form to the best of my ability but need help understanding some of the words or questions on this form. I will follow with the HSA staff and/or the treating clinician to get my questions answered.

Patient Name: _____ Signature: _____ Date: _____

If patient is unable to sign this form or does not make own decisions, please write your name and sign below.

Name of person acting in patient's behalf: _____

Relationship to Patient: _____

Signature: _____ Date: _____

The following is to be completed by the treating clinician and reviewed with the patient/patient representative:

As the treating clinician, I have reviewed the information provided by the patient/patient representative and answered the patient's/patient representative's questions. Based on this information provided, I have discussed the initial plan and the following recommendations with the patient/patient representative.

☐ Medical Work-up and management

☐ Behavioral Health Assessment and Follow-up

☐ Substance Abuse Assessment and Follow-up

☐ Case Management

☐ Palliative/Symptom Management Care

☐ Other: _____

Clinician Name: _____

Signature: _____ Date: _____

NAME