# Health Service Alliance

To help us to give you the best care, we at Health Service Alliance (HSA) need to get to know you and ask that you complete this form to the best of your ability. If you need help filling out this form, please ask our staff for help.

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

_____ _____
**Street Address/City/ State/Zip Code** **Email**

**Date of Birth**: _____ **Age**: ____ **Gender**: Male ☐ Female ☐ Transgender ☐ Other: _____

**Contact Info**: Home/Cell Phone: _____ Other Phone: _____
OK to text/voicemail/Email: ☐ Yes ☐ No

**Social Security #** _____ **Marital**: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐Widowed ☐ Other:_____

**Racial/Ethnic Identification**: ☐ Hispanic/Latino ☐ Asian ☐ Pacific Islander ☐ American Indian/Alaskan Native ☐ Black/African American ☐ White/Caucasian ☐ Other: _____

**Preferred Language**:☐ English ☐ Spanish ☐ Cantonese ☐ Mandarin ☐ Tagalog ☐ Vietnamese Other:_____

**Person to contact in case of an emergency: Name:**_____

**Relationship**: _____ **Phone#**: _____ **Email**: _____

**Total Monthly Income:** _____ **Total # of persons in your household:** _____

**Health insurance:** ☐ None; Primary Insurance: _____ Secondary Insurance:_____

**Reason for Seeking Care:** ☐ Medical ☐ Behavioral Health ☐ Other: _____

**Preferred Pharmacy:** _____

**Preferred Hospital/Date of most recent hospital stay:** _____

**Social History-** Please check all boxes that apply. If you are not comfortable answering, skip to the next section.

| | |
|---|---|
| **Behavioral Health History:** ☐ Yes ☐ No; if yes<br>**Have you ever experienced/sought treatment for:**<br>☐ Depression ☐ Anxiety ☐ Substance Abuse<br>Other: _____ | **Highest level of school you completed:** ☐ Less than Grade 12 ☐ High School diploma/GED ☐ college<br>☐ Vocational certification ☐ Other: _____ |
| **Difficulty addressing basic needs:** ☐ Yes ☐ No<br>☐ food ☐ finances ☐ housing ☐ Transportation<br>☐ Utilities ☐ Other: _____ | **Incarceration History:** ☐ Yes ☐ No<br>☐ Currently on probation ☐ Currently on Parole<br>☐ Discharged |
| **Disability/Assistance Needed:** ☐ Yes ☐ No<br>☐ Need help with daily routines ☐ Need help with mobility ☐ Need help with reading/writing<br>☐ Other: _____ | **Employment:** ☐ Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Disabled Other: _____<br>**Military service:** ☐ Yes ☐ No<br>☐ Active Duty ☐ Discharged |
| **Domestic Violence/Victim of Crime:** ☐ Yes ☐ No | **Safety concerns with current living environment**<br>☐ Yes ☐ No ☐ |

☐ Yes ☐ No- I would like to speak with HSA staff about possible resources for any of the concerns above.

**Acknowledgement- Please check appropriate box:**

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

☐ 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: _____

**Patient is unable to consent to treatment due to**:

☐ Patient is an adult but lacks capacity to give consent; consent will be signed by designated decision maker as indicated by patient, patient's Power of Attorney/Advance Directive or court-designated conservator. Copy of Power of Attorney/Advance Directive or conservatorship will be requested and placed on the patient record.

☐ Patient is a minor and does ***not*** meet any of the following legal categories to make own consent:

- Patient is not emancipated by court order
- Patient is not 15 or older and cannot demonstrate self-sufficiency
- Patient is not active military
- Patient has never been married
- Patient is not 12 or older and seeking care for pregnancy care or termination of pregnancy, communicable diseases, sexual assault/rape, mental health, or drug/alcohol abuse.

**If patient is unable to sign this form or does not make own decisions, please write name of person acting in the patient's behalf and sign below.**

Name of person acting in patient's behalf: _____

Relationship to Patient: _____

Signature: _____ Date: _____

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**For Staff Only:**

1. If patient has checked any boxes in Social History, please verify with the patient if they would like to speak with staff about community resources and refer to Case Management as appropriate.
2. If the patient is unable to provide consent, please ask for a copy of the Health Care Power of Attorney document if completed or a copy of the court order if the patient has a conservator.
3. If the patient is a minor and able to provide consent under the legal requirements for emancipation, please request a copy of the court order or other documentation.
4. If the patient is a minor and able to provide consent under the legal requirements for self-sufficiency, please have the minor complete and sign the form for "Self-Sufficient Minor" (available in HSA forms or in the California Hospital Association Consent Manual).