



ROCKFORD CENTER

Responsive, Reliable, Respectful Behavioral Healthcare

REGISTRATION INFORMATION

Patient Identification

Today's Date: _____ Time: _____

Thank you for choosing Rockford Center. One of our counselors will meet with you for a confidential assessment to discuss your needs options. In order to assist you and your family in identifying available resources please complete the following information.

PATIENT INFORMATION

Patient Name: _____ Patient Social Security Number: _____

Street Address: _____

City: _____ State: _____ County: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: _____ Date of Birth: _____ Age: _____ Sex: _____ Guardian/Spouse: _____

Emergency Contact: _____ Relationship: _____ Home Phone: _____ Work Phone: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Member Number / ID Number: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Social Security Number: _____ Date of Birth: _____

Address of Policy Holder: _____ Employer: _____

Secondary Insurance Company: _____ Member Number / ID Number: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Social Security Number: _____ Date of Birth: _____

Address of Policy Holder: _____ Employer: _____

How did you know to call Rockford Center? _____

What prompted you to present for an assessment today? _____

This consent is subject to revocation at any time except to the extent that action has been taken thereon. This consent will expire after the action is completed.

I, _____ give Rockford Center permission to perform an assessment.

Signature _____

I, _____ give Rockford Center permission to verify insurance benefits to assist with referral services.

Signature _____

Date of Birth: _____ Social Security #: _____ (If different from above)



ROCKFORD CENTER
 Responsive, Reliable, Respectful Behavioral Healthcare
**COMMUNICABLE DISEASE
 QUESTIONNAIRE**

Patient Identification

Name: _____ Date: _____

This brief questionnaire is a screening tool to help identify possible communicable diseases.

- Do you currently have or have you ever had:

Measles	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Mumps	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Rubella	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Chicken Pox	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hepatitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes
HIV	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Tuberculosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Other	<input type="checkbox"/> No	<input type="checkbox"/> Yes
- If the answer to any of the above is Yes, please list dates: _____
- Are you now under the care of a physician or taking any medication for a communicable disease? No Yes
 If Yes, please explain: _____
- Have you had recent contact with someone with any of the above illnesses? No Yes
 If Yes, which one(s): _____
- Have you ever been tested for Tuberculosis? No Yes If Yes, when? (Date): _____
- Have you ever tested positive for TB? No Yes
 If Yes, did you have a chest x-ray? No Yes
 Were you treated? No Yes If Yes, when? (Date): _____
 What kind of treatment? _____
- Please check Yes or No to ALL symptoms as they apply to you:

Productive Cough (3 weeks or more)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Persistent Weight Loss without Dieting	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Persistent Low Grade Fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Night Sweats	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Loss of Appetite	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Swollen Glands, usually in the Neck	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Recurrent Kidney Infections	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Shortness of Breath	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Chest Pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes
- Are you experiencing any of the following flu-like symptoms?

Fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Headache	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Extreme tiredness	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Dry Cough	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Runny/Stuffy nose	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Muscle aches	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Sore throat	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Vomiting	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Diarrhea	<input type="checkbox"/> No	<input type="checkbox"/> Yes
- Have you been in contact recently with anyone with flu-like symptoms? No Yes

FOR STAFF USE ONLY

After review of answers, what action taken: _____

Reviewed By: _____ Date / Time: _____

COLLATERAL CONTACT INFORMATION

PATIENT NAME: _____

Patient to complete left side

BIRTH DATE: _____

FAMILY / SIGNIFICANT OTHER (contact responsibility: social worker within 24 hours)

CIRCLE ONE

NAME: _____ *BIO PARENT STEP PARENT GUARDIAN FOSTER PARENT*

Home Number: _____ *ADOPTIVE PARENT SPOUSE PARTNER FRIEND FAMILY MEMBER*

Work Number: _____

Other (Cell): _____

SW Signature/Date: _____

Date/Time: _____

NAME: _____ *BIO PARENT STEP PARENT GUARDIAN FOSTER PARENT*

Home Number: _____ *ADOPTIVE PARENT SPOUSE PARTNER FRIEND FAMILY MEMBER*

Work Number: _____

Other (Cell): _____

SW Signature/Date: _____

Date/Time: _____

OUTPATIENT MENTAL HEALTH PROVIDERS (contact responsibility: social worker within 48 hours)

NAME (Psychiatrist): _____

SW Signature/Date: _____

Phone Number: _____

Staff Name: _____

NAME (Therapist): _____

SW Signature: _____

Phone Number: _____

Date: _____

ADDITIONAL CASE MANAGER / PROBATION (contact responsibility: social worker within 48 hours)

NAME: _____

SW Signature: _____

Agency: _____

Date: _____

Phone Number: _____

SCHOOL WELLNESS CENTER-complete if a member (contact responsibility: social worker before discharge)

NAME: _____

SW Signature: _____

Phone: _____

Date: _____

PLEASE COMPLETE REVERSE SIDE

REFERRAL SOURCE (contact responsibility: assessment referral staff immediately after assessment)

NAME; _____	ARC Signature/Date: _____
Phone Number: _____	Date: _____

PRIMARY CARE PHYSICIAN (contact responsibility: BD to fax d/c instructions after discharge)

NAME; _____	Staff Signature/Date: _____
Phone Number: _____	No ROI _____

SCHOOL (contact responsibility: teacher within 48 hours)

NAME; _____	Grade _____	Staff Signature/Date: _____
Phone Number: _____		Date: _____
		No ROI _____

Rockford Center

Substance Use Questionnaire

Yes No

Please answer yes or no to the following questions.

Within the last 30 days:

- | | | |
|---|-------|-------|
| 1. Have you used alcohol or drugs to calm down or relax? | _____ | _____ |
| 2. Have you used alcohol or drugs when you are alone? | _____ | _____ |
| 3. Have you forgotten things you did when you were using alcohol or drugs? | _____ | _____ |
| 4. Has anyone suggested you cut down on your drinking or drug use? | _____ | _____ |
| 5. Have you gotten annoyed when someone wants to talk about your alcohol or drug use? | _____ | _____ |
| 6. Have you gotten into trouble while using alcohol or drugs? | _____ | _____ |
| 7. Have you lied about your drinking or drug use? | _____ | _____ |
| 8. Have you missed work or school because of drinking or using drugs? | _____ | _____ |
| 9. Have you used drugs other than those required for medical reasons? | _____ | _____ |
| 10. Have you gotten into a fight while drinking or using drugs? | _____ | _____ |
| 11. Have you needed to use more to get the same effect? | _____ | _____ |
| 12. Have you used alcohol or drugs at times you planned not to? | _____ | _____ |
| 13. Have you tried to stop or reduce your alcohol or drug use? | _____ | _____ |
| 14. Have you experienced medical problems due to alcohol or drug use? | _____ | _____ |
| 15. Have you wondered if your drinking or drug use might be a problem? | _____ | _____ |
| 16. Have you felt more depressed or anxious when not using alcohol or drugs? | _____ | _____ |

Print Name

Signature / Date