Human Supports of Idaho

New Participant Application

Participant Information

Name:		Home Phone:	
Goes By:		Mobile Phone:	
Date of Birth:		Address:	
Sex:	☐ Female ☐ Other: ☐ Male ☐ Transgender		
Email:	Would you like to be added to our mailing list? ☐ Yes ☐ No		

Guardian Information

Name:		Home Phone:	
Relationship:		Mobile Phone:	
Preferred Contact Method:	☐ Home Phone ☐ Mobile Phone ☐ Email ☐ Other:	Address:	
Email:	Would you like to be added to our mailing list? ☐ Yes ☐ No		

Emergency Contact

Name:		Home Phone:	
Relationship:		Mobile Phone:	
Preferred Contact Method:	☐ Home Phone ☐ Mobile Phone ☐ Email ☐ Other	Address:	
Email:			

What services are you interested in receiving?

- ☐ Psychiatric Medication Management
- ☐ Individual Psychotherapy
- ☐ Group Psychotherapy
- ☐ Family Psychotherapy
- ☐ Drug/Alcohol Assessment (GAIN-I)
- ☐ Drug/Alcohol Treatment
- ☐ Peer Support Services
- ☐ Case Management
- ☐ Community Based Rehabilitation (CBRS)
- ☐ Skills Training and Development / Partial Care Groups
- ☐ Family Support Services
- ☐ Representative Payee Services

Coordination of Care

In an effort to provide you the best care possible, we would like to coordinate care with your current and previous service providers and request your medical records from the following providers/treatment team members (as applicable).

Service Type	Provider Name	Clinic / Agency Name	May we Coordinate Care?
Medical Care (PCP, Pediatrician, etc.)			☐ Yes ☐ No ☐ N/A
Psychiatric Medication Management:			☐ Yes ☐ No ☐ N/A
Pharmacy:			☐ Yes ☐ No ☐ N/A
Mental Health Psychotherapy:			☐ Yes ☐ No ☐ N/A
Mental Health Community Based Services: (Case Management, CBRS, Peer Support)			☐ Yes ☐ No ☐ N/A
Drug / Alcohol (SUD) Treatment:			☐ Yes ☐ No ☐ N/A
IDHW Child Protection Services:			☐ Yes ☐ No ☐ N/A

Are you currently on Probation or Parole? ☐ Yes ☐ No

Probation / Parole Officer:	Probation / Parole Office	
Start Date:	☐ Ada County Misdemeanor Probation ☐ Canyon County Misdemeanor Probation ☐ Idaho Department of Corrections ☐ Other:	☐ Yes ☐ No ☐ N/A

Inpatient Behavioral Health Treatment Provider (Check Each Provider you have received services from)	Approx. Month/Year of Treatment	May We Coordinate Care?
☐ Allumbaugh House		☐ Yes ☐ No ☐ N/A
☐ Idaho State Hospital North		☐ Yes ☐ No ☐ N/A
☐ Idaho State Hospital South		☐ Yes ☐ No ☐ N/A
☐ Intermountain Hospital		☐ Yes ☐ No ☐ N/A
☐ Saint Alphonsus Behavioral Health		☐ Yes ☐ No ☐ N/A
☐ SafeHaven Hospital		☐ Yes ☐ No ☐ N/A
☐ St. Luke's Canyon View Behavioral Health		☐ Yes ☐ No ☐ N/A
☐ West Valley Medical Center Behavioral Health		☐ Yes ☐ No ☐ N/A
☐ Other:		☐ Yes ☐ No ☐ N/A

Other Current Providers: (Check Each Provider you have received services from)	May We Coordinate Care?
☐ Ada County Drug Court	☐ Yes ☐ No ☐ N/A
☐ Ada County Mental Health Court	☐ Yes ☐ No ☐ N/A
☐ Canyon County Drug Court	☐ Yes ☐ No ☐ N/A
☐ Canyon County Mental Health Court	☐ Yes ☐ No ☐ N/A
☐ Idaho Department of Health and Welfare Behavioral Health	☐ Yes ☐ No ☐ N/A
☐ MTM Transportation	☐ Yes ☐ No ☐ N/A
☐ Other:	☐ Yes ☐ No ☐ N/A

Chief Complaint, Symptoms, and Stressors:

Describe your symptoms, when they started, how often you have them, what triggers them, what makes them worse, what makes them better, etc…

Mental Health History

Have you been diagnosed with any of these conditions?	Age Symptoms Started	Age You Were Diagnosed
☐ Autism Spectrum Disorder		
☐ Attention Deficit/Hyperactivity Disorder		
☐ Bipolar Disorder		
☐ Borderline Personality Disorder		
☐ Drug or Alcohol Use Disorder		
☐ Eating Disorder		
☐ Generalized Anxiety Disorder		
☐ Major Depressive Disorder		
☐ Obsessive Compulsive Disorder		
☐ Panic Disorder		
☐ Posttraumatic Stress Disorder		
☐ Schizoaffective Disorder		
☐ Schizophrenia		
☐ Other:		

Trauma History

Have you experienced any of these traumas as a victim or a witness? Have your harmed others in any of these ways?	Victim	Witness	Perpetrator
Bullying	☐	☐	☐
Emotional Abuse	☐	☐	☐
Homelessness	☐	☐	☐
Natural Disaster (Earthquake, Tornadoe, Fire, Hurricane, etc.)	☐	☐	☐
Neglect	☐	☐	☐
Physical Abuse	☐	☐	☐
Sexual Abuse	☐	☐	☐
War	☐	☐	☐
Other:	☐	☐	☐

Some people are willing to talk about their trauma. Others are not ready to talk about it yet. What is your preference?

- ☐ I am willing to talk about my trauma
- ☐ I am not willing to talk about my trauma

Substance Abuse History

Substance Type	Current Use (w/in last 30 days)	History of use, Sober 1-3 Months	History of use, Sober 3-12 months	History of use, Sober more than 1 year	No History of Use / Abuse
Alcohol	☐	☐	☐	☐	☐
Nicotine	☐	☐	☐	☐	☐
Illicit Drugs	☐	☐	☐	☐	☐
Prescription and Over-The-Counter Medications	☐	☐	☐	☐	☐

What is/was your drug(s) of choice?

- ☐ Alcohol
- ☐ Cannabis (Marijuana, Pot, Weed, etc.)
- ☐ Depressants (Downers, Klonopin, Valium, Xanax, etc.)
- ☐ Hallucinogens (Acid, Shrooms, Peyote, Ecstacy, Angel Dust, PCP, etc.)
- ☐ Inhalants (Solvents, Aerosols, Gases, Nitrites, etc.)
- ☐ Opiates (Codeine, Heroin, Methadone, Morphine, Vicodin, etc.)
- ☐ Stimulants (Cacaine, Crack, Crank, Cystal, Meth, Speed, etc.)
- ☐ Other:

Medical History

Do you have any current or previous medical problems?

- ☐ Arthritis
- ☐ Cancer
- ☐ Chronic Pain
- ☐ COPD
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Lung Disease
- ☐ Migraines/Reoccurring Headaches
- ☐ MRSA
- ☐ Neurological Problems
- ☐ Sexually Transmitted Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other:

Have you ever experienced a traumatic brain injury? ☐ **Yes** ☐ **No**

If yes, please describe, including how, what, when:

Have you been prescribed any medications?

- ☐ No, I am not prescribed any medications.
- ☐ Yes, I am taking all of them
- ☐ Yes, I am taking some of them
- ☐ Yes, but I don't take them

Medication List (Please list all of your medications here.)**:**

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Do you have any drug or food allergies? ☐ **Yes** ☐ **No**

If yes, what are they, and what is the allergic reaction (e.g., rash, breathing difficulties)?