Orange County Department of Mental Health
Child and Family Outpatient Clinic

APPLICATION FOR SERVICES

Legal Name: _____
(No Abbreviations or Nick Names) (Last) (First) (Middle)

Gender:
☐ Male ☐ Female

Date of Birth: _____ **Age**: _____ **Social Security #:** _____

Who referred you to us? _____

Permission to Contact after Discharge: ☐ Yes ☐ No

Current Living Situation:

☐ Private Residence ☐ Inpatient Setting/RTF ☐ Community Residence
☐ Adult Home ☐ Boarding Home/Foster Care ☐ Homeless/Shelter
☐ Other: _____

Parental Status:

☐ No Children ☐ Children over 18 ☐ Minor Children (with custody)
☐ Minor Children (without custody) ☐ Unknown

Address: _____
(Street)

_____
(Mailing Address, if different)

_____
(City) (State) (Zip Code) (County)

Home Phone: (____) - ____ - _____ **Cell Phone:** (____) - ____ - _____

Work Phone: (____) - ____ - _____

Primary Language:

☐ English
☐ Spanish
☐ Sign Language
☐ Other: _____

Race:

☐ White
☐ Black/African America
☐ Asian
☐ Unknown
☐ American Indian/Alaska Native
☐ Native Hawaiian/other Pacific Islander
☐ Other: _____

Hispanic Ethnicity: ☐ No, not Hispanic/Latino ☐ Yes, Hispanic/Latino ☐ Unknown

Place of Birth: _____
(City) (State) (Country)

County Of Birth: _____

Previous Legal Names, If Any (Maiden name): _____

Marital Status
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Highest Level of Education Completed:

☐ No formal Education ☐ 1st Grade ☐ 2nd Grade ☐ 3rd Grade ☐ 4th Grade ☐ 5th Grade
☐ 6th Grade ☐ 7th Grade ☐ 8th Grade ☐ 9th Grade ☐ 10th Grade ☐ 11th Grade
☐ 12th grade
☐ High School Diploma/GED ☐ Business/Technical Training ☐ Some College
☐ Associate's Degree ☐ Bachelor's Degree ☐ Graduate Degree
☐ Other

Current School: _____

Special Education Services:

☐ Yes ☐ No ☐ Unknown

If Yes, what is/was your classification:

☐ Emotional Disturbance ☐ Learning Disability ☐ Sensory Impairment
☐ Physical Disability ☐ Other Health Impairment ☐ Multiple Disabilities
☐ Autism Spectrum ☐ Unknown

Current Employment Status:

☐ Competitive Employment ☐ Other Employment ☐ Non-Paid Work (Volunteer)
☐ Unemployed: looking for work ☐ Unemployed: Not looking for work

Usual Hours Worked Per Week
☐ Not Applicable ☐ 1-14 hours ☐ 15-34 hours ☐ 35+ hours ☐ Unknown

Occupation: _____

Employer: _____

Household Composition (check all that apply)

☐ Not in Private Residence ☐ Live Alone ☐ Live with Parent
☐ Live with Siblings ☐ Live with Spouse/Partner ☐ Live with other relative(s)
☐ Live with others/unrelated ☐ Live with child/stepchild/foster child/Grandchild

Veteran: ☐ Yes ☐ No ☐ Unknown

Military Related Disability: ☐ Yes ☐ No

Current Disabilities/Disorders

☐ Mental Illness ☐ Intellectual Disability/Mental Retardation ☐ Autism Spectrum
☐ Alcohol Related ☐ Developmental Disability ☐ Substance Related
☐ Physical Disability

Chronic Medical Conditions

☐ High blood fat/cholesterol ☐ High Blood Pressure ☐ Diabetes
☐ Obesity ☐ Heart Attack ☐ Stroke
☐ Other Cardiac Condition ☐ Pulmonary (COPD, Asthma) ☐ Alzheimer/Dementia
☐ Kidney Disease ☐ Liver Disease ☐ Endocrine Condition
☐ Neurological Condition (MS) ☐ Traumatic Brain Injury ☐ Cancer
☐ Joint disease (Lupus, arthritis) ☐ None of the above ☐ Unknown

Financial Information:

☐ Unemployment ☐ Workmen's Comp ☐ Pension
☐ VA Disability benefits ☐ Public Assistance ☐ SSDI
☐ VA Cash Assistance ☐ Private Income/Family ☐ SSI

☐ Medicaid #_____Sequence#____
☐ Medicare #_____
☐ Other (please specify)_____

Criminal Justice or Juvenile Justice Status:

☐ None
☐ Criminal Procedure Law 330.20 ☐ Parolee (adults)
☐ Article 10-Sexes Offender Management/Treatment ☐ Probationer (adults)
☐ Adjudicated Juvenile Delinquent/Offender ☐ PINS
☐ Alternative to Incarceration (STI, Diversion) ☐ Other Criminal Justice Status

Is this the first time you have received services at this Clinic?
☐ Yes ☐ No

Have you ever been treated for emotional or mental health problems?
☐ Yes ☐ No

(Please list all, including past treatment at Orange County Mental Health Clinics)

DATE	DOCTOR OR AGENCY	REASON

What would you like to address in treatment?

1. _____
2. _____
3. _____

This Application Was Completed By:

Signature: _____ **Date:** _____

Parent/Guardian:

_____ **Relationship to Client** _____
(Name)

_____
(Street)

_____
(City) (State) (Zip Code)

_____

Phone Number: (____) - ____ - _____

Permission To Treat A Minor

I authorize the Orange County Department of Mental Health Child and Family Outpatient Clinic to provide services to my child, _____, for such treatment as recommended by OCDMH staff. This may include the prescribing of medication by medical staff, only with my knowledge.

Signature of Parent or Guardian:

_____ _____
(Signature) (Print Name)

_____ _____
(Date) (Witness)