CONTRA COSTA ALCOHOL & OTHER DRUGS SERVICES
A Program of Behavioral Health Services

Client Registration

Confidential Patient Information under HIPAA & 42 CFR Part 2

MRN:

Current Name:

Facility Name: ID:

Program Name (Level of Care): ID:

☐Client Registration

☐Client Update

NAME

SSN#: Mother's Maiden Name:

Birth Last Name: First Name: Date of Birth:

Alias Last Name: First Name: Begin Date:

ADDRESS (check 1 response)

☐Home ☐Work ☐Shelter ☐Homeless ☐Foreign ☐Unknown

Street:
(Ex. 1234 N Main St Apt #123)

City: State: Zip + 4:

Begin Date:

TELEPHONE

Home: Begin Date:

Cell: Begin Date:

DEMOGRAPHICS (choose 1 response only for each question below)

Gender:

☐Male
☐Female
☐Other
☐Unknown

Marital Status:

☐Married
☐Single
☐Separated
☐Divorced
☐Widowed
☐Not Collected
☐Unknown

Legal/Court Status (WI Codes):

☐Juvenile Ct, Dependent of the Court (Section 300)
☐Juvenile Ct, Ward – Status Offender (Section 601)
☐ Juvenile Ct, Ward-Juvenile Offender (Section 602)
☐ Incarceration Non-Specific
☐ Not Applicable
☐ Post Release Community, Supervision

Occupation Type:

☐Executive/Managerial
☐Farming/Forestry
☐Production/Labor
☐Sales/Service
☐Unemployed
☐Unknown/Not Reported

Employment Status:

☐Full time, > 35 Hrs/wk (compensated)
☐Full time, > 35 Hrs/wk (non-comp)
☐Part time, < 35 Hrs/wk (compensated)
☐Part time, < 35 Hrs/wk (non-comp)
☐Retired
☐Disabled
☐Volunteer Work
☐Unemployed, Seeking Work
☐Unemployed, Not Seeking Work
☐Student, Full Time
☐Student, Part Time
☐Student, Employed Part Time
☐Homemaker, Seeking Work
☐Homemaker, Not Seeking Work
☐Full-Time Training
☐Part-Time Training
☐Resident/Inmate of Institution
☐Other
☐Unknown/Not Reported

Residential Living Arrangement:

☐Adult Residential Facility
☐Community Treatment Facility
☐Crisis Residential Facility
☐Drug Abuse Facility
☐Foster Family Home
☐General Hospital
☐Group Home (Level 1-12 Child)
☐Group Quarters
☐Homeless, No Identifiable Residence
☐House or Apartment
☐House or Apartment w/ Supervision (Recovery Res)
☐House or Apartment w/ Support (SLE)
☐Inpatient Psychiatric / PHF
☐Institute of Mental Disease (IMD)
☐Justice Related
☐Large Board & Care
☐MH Rehab Center (24-hour)
☐Other
☐Res Tx Center (Level 13-14 Child)
☐Satellite Housing
☐Single Room
☐Small Board & Care
☐SNF / ICF
☐SNF / ICF – Psych Reason
☐State Hospital
☐Supported Housing
☐Temporary Arrangement
☐Unknown/Not Reported
☐VA Hospital

DEMOGRAPHICS CONT. (choose 1 response only for each question below, unless otherwise specified)

Hispanic Origin:

☐Not Hispanic
☐Mexican/Mexican American
☐Cuban
☐Puerto Rican
☐Other Hispanic/Latino
☐Hispanic
☐Unknown/Not Reported

Race (check all that apply):

☐Alaskan Native
☐American Indian
☐Asian Indian
☐Black or African American
☐Cambodian
☐Chinese
☐Filipino
☐Guamanian
☐Hmong
☐Japanese
☐Korean
☐Laotian
☐Latin American
☐Mexican American
☐Mien
☐Mixed Race
☐Native Hawaiian
☐Other
☐Other Asian
☐Other Hispanic
☐Other Pacific Islander
☐Other Southeast Asian
☐Samoan
☐Vietnamese
☐White or Caucasian
☐Unknown/Not Reported

Primary Language:			**Preferred Language:**		
☐American Sign Language	☐Ilocano	☐Polish	☐American Sign Language	☐Ilocano	☐Polish
☐Arabic	☐Italian	☐Portuguese	☐Arabic	☐Italian	☐Portuguese
☐Armenian	☐Japanese	☐Russian	☐Armenian	☐Japanese	☐Russian
☐Cambodian	☐Korean	☐Samoan	☐Cambodian	☐Korean	☐Samoan
☐Cantonese	☐Lao	☐Spanish	☐Cantonese	☐Lao	☐Spanish
☐English	☐Mandarin	☐Tagalog	☐English	☐Mandarin	☐Tagalog
☐Farsi	☐Mien	☐Thai	☐Farsi	☐Mien	☐Thai
☐French	☐Other Chinese	☐Turkish	☐French	☐Other Chinese	☐Turkish
☐Hebrew	☐Other Non-English	☐Vietnamese	☐Hebrew	☐Other Non-English	☐Vietnamese
☐Hmong	☐Other Sign Lang.	☐Unknown	☐Hmong	☐Other Sign Lang.	☐Unknown

Education:	**Accommodations (check all that apply):**	**Identification**
☐None ☐Grade (Indicate Highest Grade Completed Below): ☐Client Declined to State ☐Other (including Vocational) ☐Unknown/Not Reported	☐None ☐Visual ☐Hearing ☐Speech ☐Mobility ☐Mental ☐Developmentally Disabled ☐Other Disability	Driver's License #: Driver's License State: Mother's First Name: State of Birth: County of Birth:

CONTACT INFORMATION (with appropriate signed releases in place)

Relation to Consumer: Contact Type: ☐Emergency ☐Message

Last Name: First Name:

Home Phone Social Security Number: 999-99-9999

AOD Counselor Printed Name/Title | AOD Counselor Signature/Title | Date

Date of Entry:

Time of Entry: _____ Data Entry Staff Initials: _____ Data Entry Staff ID: _____