

HENRICO AREA MENTAL HEALTH & DEVELOPMENTAL SERVICES  
CLIENT ADMISSION

Date: \_\_\_\_\_

FOR OFFICE USE ONLY  
Case Number: \_\_\_\_\_  
For PIP Program, enter Child ID Code: \_\_\_\_\_  
Client Status: ( ) Pre-Registered ( ) Registered ( ) Admit

\*Name of Client: \_\_\_\_\_  
Last Name Suffix (Jr., Sr. III) First Name MI

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ \*Social Security#: \_\_\_\_\_

If custody/visitation order, name(s) of child (ren): \_\_\_\_\_  
\_\_\_\_\_

Street Address: \_\_\_\_\_ Apartment Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\*In what type of residence do you live (current location)?

- Boarding Home
- Community Residential (group home)
- Foster Home/Family Sponsor
- Homeless/Homeless Shelter
- Hospital
- Licensed Adult Care Residence (ACR)
- Local Jail or Detention
- Nursing Home/Physical Rehabilitation
- Other
- Other Institutional Setting
- Private Residence/School Dormitory**
- Residential Treatment/Alcohol & Drug Rehabilitation
- Shelter
- State Correctional Facility

\*In what county do you currently live? If you reside in a group home or state facility, what county did you live in previously? (If homeless, check Henrico County).

- Charles City County
- Chesterfield County
- Goochland County
- Hanover County
- Henrico County**
- New Kent County
- Powhatan County
- Richmond City
- Other \_\_\_\_\_

Phone number where we may contact you: (If you do not wish to be contacted, leave blank) ( ) \_\_\_\_\_

Work phone: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_ Other phone (pager, cell, etc.): ( ) \_\_\_\_\_

**Primary Emergency Contact Person:**

\_\_\_\_\_  
Last Name First Name Middle Initial

Relationship to you: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apartment Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: ( ) \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_ Other phone: ( ) \_\_\_\_\_

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**Secondary Emergency Contact Person:**

\_\_\_\_\_  
Last Name First Name  
Street Address: \_\_\_\_\_ Apartment Number: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home phone: ( ) \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_ Other phone: ( ) \_\_\_\_\_

**May we send correspondence to the following addresses during and/or after services?**

Address of Client  Yes  No  
Address of Primary Emergency Contact  Yes  No  
Address of Secondary Emergency Contact  Yes  No

**Legal Guardian**

\*Legal (Guardian) Status:  
 No Legal Guardian  Eighteen +, has legal guardian  
 <18: Ward of DSS or Corrections  <18: Non DSS or Corrections Legal Guardian  
 Authorized Representative  Protective Payee

***If there is a Guardian, complete:***

Name of Legal Guardian: \_\_\_\_\_  
Last Name First Name  
Street address: \_\_\_\_\_ Apartment Number: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home phone: ( ) \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_

\* Are you a minor?  YES  NO If yes, with whom do you live?

\_\_\_\_\_  
Last Name First Name \*Relationship to you

If you are a minor, please provide parents/caregivers names:

\_\_\_\_\_  
Last Name of Mother First Name Middle Initial

\_\_\_\_\_  
Last Name of Father First Name Middle Initial

\_\_\_\_\_  
Last Name of Other Caregiver First Name Middle Initial \*Relationship to you

\*Gender:  Male  Female If female, are you living with dependent children ages 0-17?  Yes  No  Unknown

\*What is your marital status?  Never Married  Married  Separated  Divorced  Widowed

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\*What is your race?

- |   |  |
|---|--|
| <input type="radio"/> Black/African-American                              | <input type="radio"/> Multi-Racial                     |
| <input type="radio"/> American Indian or Alaska Native & White            | <input type="radio"/> Alaskan Native                   |
| <input type="radio"/> Asian & White                                       | <input type="radio"/> Other                            |
| <input type="radio"/> African-American & White                            | <input type="radio"/> Native Hawaiian/Pacific Islander |
| <input type="radio"/> American Indian or Alaska Native & African-American | <input type="radio"/> Asian                            |
| <input type="radio"/> American Indian                                     | <input type="radio"/> White/Caucasian                  |

\*Are you of Hispanic origin?

- |                               |   |   |
|-------------------------------|---|---|
| <input type="radio"/> Cuban   | <input type="radio"/> Puerto Rican          | <input type="radio"/> Not of Hispanic Origin                  |
| <input type="radio"/> Mexican | <input type="radio"/> Other Hispanic Origin | <input type="radio"/> Hispanic Specific Origin not identified |

What is your primary language?  English  Other: \_\_\_\_\_

\*How many prior treatment episodes have you received in any drug/alcohol treatment programs? \_\_\_\_\_  
(Enter zero, if this is the first treatment or you have never been in a drug/alcohol treatment program.)

**Employment and Education Information:**

\*Current employment status:

- |  |  |
|--|--|
| <input type="radio"/> Disabled: Unable to Work       | <input type="radio"/> Other (includes unemployed and NOT seeking employment) |
| <input type="radio"/> Employment Program             | <input type="radio"/> Part-time (<35 hours per week)                         |
| <input type="radio"/> Full-time (>35 hours per week) | <input type="radio"/> Retired  |
| <input type="radio"/> Homemaker                      | <input type="radio"/> Student/Job Training (FT or PT, no paid employment)    |
| <input type="radio"/> Institution or Jail            | <input type="radio"/> Unemployed: Looking                                    |
| <input type="radio"/> Not in Labor Force             |  |

\*What is the highest grade you completed in school?

- |  |   |
|--|---|
| <input type="radio"/> Associate's Degree             | <input type="radio"/> Graduate/Professional Degree          |
| <input type="radio"/> Bachelor's Degree              | <input type="radio"/> Never Attended School                 |
| <input type="radio"/> Certificate of Completion      | <input type="radio"/> Preschool/Kindergarten                |
| <input type="radio"/> Completed Elementary (thru 8)  | <input type="radio"/> Some College                          |
| <input type="radio"/> Completed HS / Vocational Educ | <input type="radio"/> Some Elementary (Grades 1-7)          |
| <input type="radio"/> GED                            | <input type="radio"/> Some High School/Vocational Education |

**Military Status:**

- |   |   |
|---|---|
| <input type="radio"/> Armed Forces – Active Duty          | <input type="radio"/> Discharged Armed Forces/National Guard              |
| <input type="radio"/> Armed Forces - Reserves             | <input type="radio"/> Dependent Family Member                             |
| <input type="radio"/> National Guard – not mobilized      | <input type="radio"/> Never been in the Military/not a Military Dependent |
| <input type="radio"/> Retired Armed Forces/National Guard |   |

If military, discharged or retired what was the year you began? \_\_\_\_\_ If discharged/retired what was the year you left? \_\_\_\_\_

**General Medical Information:**

Preferred Primary Care Physician: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physician's Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Name of Preferred Clinic or Hospital: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Do you have any allergies?  Yes  No  Unknown

If yes, to what medications, foods or environmental conditions? \_\_\_\_\_

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**I hereby apply for the services of Henrico Area Mental Health & Developmental Services for myself as a Client or for the above named person whom I am legally authorized to represent and to act in his or her behalf.**

**I understand that use and disclosure of my information is governed as set out in the Privacy Notice that has been provided to me.**

**I have been informed that in the event I am seen with members of my family or anyone else, any participant in a session shall have equal rights to obtain and release information obtained during that session. Upon request, a separate chart will be established for any individual. If you have any questions about confidentiality, please ask your Clinician or Case Manager.**

**I understand that in the event of a medical emergency, qualified medical personnel will be contacted to administer the appropriate medical treatment.**

**I acknowledge that my records will be destroyed six (6) years after my last treatment, or six (6) years after I reach the age of majority, whichever is greater per the General Schedule 18 for Local Governments of Virginia.**

It is recommended, as part of your initial comprehensive assessment, that you provide documentation of a current medical examination. You are asked to arrange this through your physician. If you do not have a physician, you may request help in obtaining one. Even though we encourage this, you have the right to decline and this will not affect the services for which you are eligible.

Do you wish to register to vote?

I am registered or not eligible       Yes       No

\_\_\_\_\_  
Signature of Client or Authorized Representative

\_\_\_\_\_  
Date

**Please Note: This form, which includes consent to treatment, must be completed before services can begin. If the legal guardian is unable to attend the initial appointment, he/she may show verification of guardianship and proof of identity to a Notary Public. The Notary Public should complete the section below and notarize (with seal). This notarized form, along with copies of the guardianship papers and proof of identity, may be submitted in person by a substitute custodian or via mail:**

**Access  
Henrico Mental Health & Developmental Services  
10299 Woodman Road  
Glen Allen, Virginia 23060**

**804-727-8515 for questions**

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If applicable: Verification of Guardianship or Authorized Representative: (e.g. court order)

- Verification copied for Medical Record
- Identify verified and proof of Identity copied for Medical Record

Notary Public verification (if Client Admission completed out of office)

Name of Notary Public: (please print) \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public

Expiration of Commission: \_\_\_\_\_

Seal:

Completed by: _____	Staff Code: _____
Keying Staff Code: _____	Date Keyed: _____