CORSICA RIVER
*Providing Behavioral Health Services on the Mid-Shore*

# CORSICA RIVER MENTAL HEALTH SERVICES, INC.


120 BANJO LANE
CENTREVILLE, MD 21617
Phone (410) 758-2211
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403 HIGH STREET
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Phone (443) 225-5780
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Phone (410) 479-0511
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Thank you for your interest in Mobile Treatment Services with Corsica River Mental Health Services, Inc. The enclosed packet contains the items you will need to complete prior to enrolling in Mobile Treatment services. Along with the enclosed packet of information, we need you to provide the following documentation:

- ☐ All current Insurance Cards - primary and secondary*
- ☐ Photo ID
- ☐ Patient Social Security Card
- ☐ Primary Medical Doctors name, address and phone number
- ☐ List of all Medications

- Please tell us if you do not have one or more of the documents listed above.

It is requested you bring the following, if applicable:

- ☐ Reports from previous psychological evaluations/testing

Mobile Treatment is a volunteer service. We offer a team approach. It is expected that our clients work with all team members to gain the maximum benefit of our services.

**Acceptance and scheduling for an Intake is dependent on qualifying for services and if required, to obtain authorizations for services.**

**PLEASE NOTE: Failure to provide all necessary documents will delay our being able to schedule.**

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# Mobile Treatment Client Registration Form

**PLEASE PRINT CLEARLY** **Date:** _____

## Client Information

Client's Name: _____ Preferred Name (nickname) _____

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Phone#: (home) _____ (work) _____ (cell) _____

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

Race: _____ Marital Status: _____

Gender: _____ Male _____ Female _____ Male to Female _____ Female to Male

## Preferred Method of Communication (please check one and complete)

_____Email (please provide if different than above) _____

_____Phone (please designate number) _____

_____Text (please designate number) _____

Employed: _____ Full Time _____ Part Time _____ Not Employed Are you a Veteran? ____ Yes ____ No

Employer: _____

Address: _____ Phone: _____

## Primary Insurance Information

Company Name _____

Member ID No. _____ Group No. _____

Name of Insured _____

Address if different from above _____

_____

Insured's Phone (home) _____

(work) _____ (cell) _____

Birth Date _____ Social Security _____

Insured's Employer _____

## Secondary Insurance Information

Company Name _____

Member ID No. _____ Group No. _____

Name of Insured _____

Address if different from above _____

_____

Insured's Phone (home) _____

(work) _____ (cell) _____

Birth Date _____ Social Security _____

Insured's Employer _____



Rev. 12/12; 2/18; 4/18; 8/18/; 3/19

## Primary Emergency Contact

Name: _____ Address: _____

Phone #: (home/cell) _____ (work) _____ Relationship: _____

## *Two Additional Emergency Contacts (*_required if the client is a minor_)

**Name**: _____ Address: _____

Phone #: (home/cell) _____ (work) _____ Relationship: _____

**Name**: _____ Address: _____

Phone #: (home/cell) _____ (work) _____ Relationship: _____

## Referral Information

**Are you related to, or in a relationship with an employee of Corsica River Mental Health Services or Crossroads Community, Inc.? _____Yes _____No (If Yes, please list their name and relationship)**

**Name _____Relationship_____**

**Explain reason for referral** _____

_____

_____

_____

**Referred by?** _____Self_____ Doctor _____ Family Member _____ Probation Officer_____ Legal/Court Issues _____*Other

***(Other – please explain)** _____

**Previous Psychological Testing?** Y/N _____ *(please bring copies to your first appointment)*

---

**Primary Care Physician**: _____ Phone#: _____

Address: _____

Date last seen: _____ Allergies (all types):_____

**Current Medications**: _____

_____

_____

_____

**Significant Medical History** (include developmental difficulties, allergies, surgeries, illnesses, etc. with approximate dates):

_____

_____

**Significant Legal History**:_____

_____

_____

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***FOR AGES 12 AND UP ONLY***


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# Patient Depression Screening

Patient Name:_____ Date of Visit:_____

| Over the past 2 weeks, how often have you been bothered by any of the following problems? | Not at all | Several Days | More than on-half of the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |

## CAGE-AID Questionnaire

When thinking about drug use, include illegal drug use and the use of prescription drug other than prescribed.

| **Questions:** | **Yes** | **No** |
|---|---|---|
| 1. Have you ever felt that you ought to cut down on your drinking or drug use? | ☐ | ☐ |
| 2. Have people annoyed you by criticizing your drinking or drug use? | ☐ | ☐ |
| 3. Have you ever felt bad or guilty about your drinking or drug use? | ☐ | ☐ |
| 4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? | ☐ | ☐ |

**Scoring**
Regard one or more positive responses to the CAGE-AID as a positive screen.

**Psychometric Properties**

| The CAGE-AID exhibited: | **Sensitivity** | **Specificity** |
|---|---|---|
| One or more **Yes** responses | 0.79 | 0.77 |
| Two or more **Yes** responses | 0.70 | 0.85 |

(Brown 1995)

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***--FOR AGES 16 AND UP ONLY***

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# Mental Health Screening Form-III (MHSF-III)

Date of Screening:_____

Number of days since last use of alcohol and/or other drugs:_____

Please note that the following questions refer to your entire life history, not just your current situation. This is why each question begins with "Have you ever".

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? YES_____ NO_____

2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? YES_____ NO_____

3. Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? YES_____ NO_____

4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? YES_____ NO_____

5. Have you ever heard voices No one else could hear or seen objects or things which others could not see? YES_____ NO_____

6. **a.** Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? YES_____ NO_____

   **b.** Did you ever attempt to kill yourself? YES_____ NO_____

7. Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? YES_____ NO_____

8. Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?
   YES_____ NO_____
9. Have you ever given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property? YES_____ NO_____

10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? YES_____ NO_____

11. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? YES_____ NO_____

12. Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up? YES_____ NO_____

13. Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly Non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything? YES_____ NO_____

14. Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint? YES_____ NO_____

15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate. YES_____ NO_____

16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling? YES_____ NO_____

17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem? YES_____ NO_____

## Scoring

*Score (Questions 1 and 2 are not scored)

Number of "Yes " answers:_____

*Screened positive = a score of 1(one) or greater