SHEBOYGAN COUNTY HEALTH AND HUMAN SERVICES
DIVISION OF COMMUNITY PROGRAMS

Client #:______________
Date: ________________

OWI APPLICATION FOR SERVICES

Date of Birth: _____ - _____ - ________ Soc. Sec. No: _________ - _____ - _______ Gender: M F

Name: Last:____________________________________ First:____ MI:_________

Address:____ City:____________________________ State: WI Zip:_____________

Phone Number: _________________________________ Email Address: ____

Driver's License Number/ID # ____

Marital Status: Single M W Sep Div Maiden Name:________________________________

Employer: ____ Hrs / Shift: ____________________________

Interpreter: ☐ No ☐ Yes Language Spoken: Spanish ☐ Hmong ☐ Burmese ☐

# of Lifetime OWI'S: _____ Arresting Agency: ____

If under AGE OF 18, a parent will need to accompany to the OWI appt.: ☐ No ☐ Yes

If client will be in jail at time of OWI appt., please have client bring appointment sheet with them to jail.

MEDICAL/SOCIAL HISTORY

NAME: ______________________ DOB: ____________ DATE: ____________

Address: ______________________________ Phone: ______________

Emergency Contact: ______________ Relationship: ______________ Phone: ______________

Gender: M F Race: ______________ Number of Lifetime OWIs: ____________

Place of Employment: ______________ Driver License Number: ______________

Please check those that apply:

- ☐ Asthma
- ☐ Seizure or convulsion
- ☐ Hydrocephalus
- ☐ Meningitis
- ☐ Unconsciousness
- ☐ Encephalitis
- ☐ Hearing Problems
- ☐ Vision Problems
- ☐ Speech Problems
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ STDs ______________
- ☐ Head Injury – How Many? ____________
- ☐ Other Medical Issues ______________________________

Primary Care Physician: ______________________________

Surgery or Hospitalization	Date(s)	Reason	Length of Stay

Describe significant injuries or accidents you may have experienced: ______________________________

____

Please list any medications previously prescribed to you for emotional problems (anxiety, depression, bipolar, ADHD):

____

____

CURRENT MEDICATIONS: (please include mental health and medical medications)

Medication	Dose	Frequency	Prescriber

ALLERGIES: ______________________________

Do you use tobacco? ☐ yes ☐ no How often? ______________ Attempts to quit? ________

Do you use caffeine? ☐ yes ☐ no How often? ______________ Attempts to quit? ________

Do you use alcohol? ☐ yes ☐ no How often? ______________ Attempts to quit? ________

Do you use illegal drugs? ☐ yes ☐ no How often? ______________ Attempts to quit? ________

Ever used IV drugs? ☐ yes ☐ no How often? ______________ Attempts to quit? ________

Ever abused prescription drugs? ☐ yes ☐ no How often? ______________ Attempts to quit? ________

Indicate which family members (blood relatives through great grandparents) are affected by the following:

Bipolar ______________________

Anxiety ______________________

Depression ______________________

Schizophrenia ______________________

Excessive drug use ______________________

Excessive alcohol use ______________________

Excessive gambling ______________________

Please check any symptoms you may be experiencing at this time, even if they are listed in more than one place:

A.
- ☐ Poor appetite and/or weight loss
- ☐ Overeating and/or weight gain
- ☐ Difficulty sleeping
- ☐ Sleeping too much
- ☐ Feelings of worthlessness
- ☐ Crying spells
- ☐ Low self-esteem
- ☐ Sadness, loneliness
- ☐ Difficulty making decisions
- ☐ Trouble concentrating
- ☐ Irritability
- ☐ Feelings of hopelessness
- ☐ Lack of interest or motivation
- ☐ Loss of interest in sex
- ☐ History of suicide attempts
- ☐ Homicidal thoughts
- ☐ Loss of enjoyment in usual activities
- ☐ Isolating from family and/or friends
- ☐ Poor self-care, cleanliness, hair, appearance
- ☐ Suicidal thoughts
- ☐ Suicidal plans

B.
- ☐ Muscle tension
- ☐ Restlessness or feeling keyed up
- ☐ Trouble concentrating
- ☐ Worry too much
- ☐ Tire easily, fatigue

C.
- ☐ Racing heartbeat
- ☐ Tightness in chest
- ☐ Fear of having a heart attack or dying
- ☐ Chills or hot flashes
- ☐ Difficulty breathing
- ☐ Fear of loss of control or going crazy
- ☐ Numbness or tingling sensation
- ☐ Obsessive thought(s)
- ☐ Counting/checking
- ☐ Specific fears/phobias
- ☐ Rituals
- ☐ Excessive cleaning
- ☐ Things needing to be in order or a certain way
- ☐ Excessive hand washing or showering

D.
- ☐ Avoidance of social events or enduring them with significant distress
- ☐ Fear of being judged or criticized
- ☐ Fear of being embarrassed in front of others
- ☐ Avoidance of talking to people I don't know
- ☐ Avoidance of activities where I am the center of attention

E.
- ☐ Headaches
- ☐ Stomachaches
- ☐ Frequent pain

F.
- ☐ Excessive spending
- ☐ Racing thoughts
- ☐ Talking too fast
- ☐ High risk activities - financial, legal, sexual
- ☐ Very little need for sleep - 2 to 3 hours per night

G.
- ☐ Shoplifting or stealing
- ☐ Gambling to escape problems
- ☐ Significant debt or relationship problems due to gambling
- ☐ Use of alcohol or drugs to feel better

H.
- ☐ Binge eating
- ☐ Regular use of laxatives
- ☐ Excessive exercising
- ☐ Self-induced vomiting
- ☐ Self-mutilation or self-harm

I.
- ☐ Inattentive
- ☐ Careless mistakes
- ☐ Forgetful
- ☐ Disorganized
- ☐ Easily distracted
- ☐ Trouble listening
- ☐ Avoid or dislikes mental tasks
- ☐ Often lose things
- ☐ Feel driven or on the go
- ☐ Talk excessively
- ☐ Fidgets a lot
- ☐ Often interrupt people - blurt out answers
- ☐ Impulsive

J.
- ☐ Nightmares related to past trauma
- ☐ Recurrent and distressful thoughts of past trauma
- ☐ Acting or feeling as if re-experiencing a past trauma
- ☐ Startled very easily
- ☐ Anger outbursts

K.
- ☐ Often angry
- ☐ Physically aggressive towards others
- ☐ Swear or name call during arguments
- ☐ Throw or break things during arguments
- ☐ Legal problems

L.
- ☐ Hearing things others don't
- ☐ Seeing things others don't
- ☐ Tactile hallucinations
- ☐ Suspicious of others
- ☐ Feeling persecuted

Please answer the following questions as they may apply to you. Check the correct answer. Some questions may have more than one answer. Please check all that apply.

1. Who primarily raised you?
   1. Natural parents
   2. Adoptive parents
   3. Mother only
   4. Father only
   5. Foster parents
   6. Family member i.e. grandparent/aunt/uncle/sibling
   7. Other

2. How many brothers and sisters do you have?______

3. How far did you go in school?
   1. Completed less than 8 grades
   2. Attended high school (no diploma)
   3. Graduated high school
   4. Received GED/HSED
   5. Attended college/technical school (did not graduate)
   6. Graduated from college/technical school
   7. Earned a masters or doctoral degree

4. How would you rate your intellectual ability?
   1. Below average
   2. Average
   3. Above average
   4. Superior/gifted

5. Have you had any major changes in your income during the last 2 years?
   1. No
   2. Decreased significantly
   3. Increased significantly

6. What is your primary source of income?
   1. My earnings
   2. My partners earnings
   3. Disability payments
   4. Unemployment
   5. Family member
   6. Investments
   7. Other

7. Are you employed?
   1. Yes
   2. No

8. How long have you been at this job?
   1. Less than 6 months
   2. 1 to 5 years
   3. 5 to 10 years
   4. 10 to 15 years
   5. 15 to 20 years
   6. More than 20 years

9. Which of the following have you used?
   1. Cocaine/crack
   2. Barbiturates
   3. Amphetamines
   4. Hallucinogenics
   5. Opium
   6. Heroin
   7. Marijuana
   8. None

10. Have you ever been involved in an alcohol or drug counseling program?
    1. Yes
    2. No

11. When you drink, about how many drinks do you consume per occasion?
    1. 1-2
    2. 3-5
    3. 5-10
    4. 10-15
    5. More than 15

12. In an average week how much do you spend on alcohol/drugs?
    1. Less than $10.00
    2. $10-$30
    3. $30-$50
    4. $50-$75
    5. More than $75

13. Have you ever experienced any of the following?
    1. Intoxication
    2. Drinking to relax
    3. Not recalling behavior when sober
    4. Feeling guilty about your behavior
    5. Staying home due to a hangover
    6. Other people being concerned
    7. Consciously trying to control use
    8. Shakes
    9. Trouble at work
    1. Divorce or loss of relationship
    2. Trouble quitting after 4 drinks
    3. Being concerned about your own use
    4. None of the above

14. Which of the following best describes your drinking/using?
    1. Total abstainer
    1. Light social drinker/user
    1. Moderate social drinker/user
    1. Heavy social drinker/user
    1. Problem drinker/user
    1. Alcohol/drug abuser
    1. Recovering alcoholic/addict

15. Which of the following do you think your spouse/family/friends would consider you?
    1. Total abstainer
    1. Light social drinker/user
    1. Moderate social drinker/user
    1. Heavy social drinker/user
    1. Problem drinker/user
    1. Alcohol/drug abuser
    1. Recovering alcoholic/addict

16. What are your living arrangements?
    1. Own/buying my home
    2. Rent my home/apartment
    3. Live with family member
    4. Live with friend
    5. Rent a room
    6. Other

17. Which of the following have you experienced in the past two years?
    1. Marriage
    2. Death of a family member
    3. Death of a close friend
    4. Job loss
    5. Change in financial status
    6. Personal injury or illness
    7. Change to a different line of work
    8. Other
    9. None of the above

18. How would you rate your ability to cope with the above situation?
    1. Very good
    2. Good
    3. Fair
    4. Poor
    5. Does not apply

19. Have you ever had previous legal problems?
    1. Convicted of a misdemeanor or civil forfeiture
    2. Convicted of a felony
    3. No

Adverse Childhood Experiences (ACE) survey Name: ____

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**…Swear at you, insult you, put you down, or humiliate you?
   OR
   Act in a way that made you afraid that you might be physically hurt? ☐ **Yes** ☐ **No**

2. Did a parent or other adult in the household **often or very often**…Push, grab, slap, or throw something at you?
   OR
   Ever hit you so hard that you had marks or were injured? ☐ **Yes** ☐ **No**

3. Did an adult or person at least 5 years older than you **ever**…Touch or fondle you or have you touch their body in a sexual way?
   OR
   Attempt or actually have oral, anal, or vaginal intercourse with you? ☐ **Yes** ☐ **No**

4. Did you **often or very often** feel that …No one in your family loved you or thought you were important or special?
   OR
   Your family didn't look out for each other, feel close to each other, or support each other? ☐ **Yes** ☐ **No**

5. Did you **often or very often** feel that …You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   OR
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? ☐ **Yes** ☐ **No**

6. Were your parents **ever** separated or divorced? ☐ **Yes** ☐ **No**

7. Was your mother or stepmother: **Often or very often** pushed, grabbed, slapped, or had something thrown at her?
   OR
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   OR
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife? ☐ **Yes** ☐ **No**

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? ☐ **Yes** ☐ **No**

9. Was a household member depressed or mentally ill, or did a household member attempt suicide? ☐ **Yes** ☐ **No**

10. Did a household member go to prison? ☐ **Yes** ☐ **No**

Total # of YES responses:__________

This is your ACE score

Thank you for providing this critical information.

SHEBOYGAN COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES REGARDING HEALTH INFORMATION

Client Name: ____

Date of Admission of Services: ______________________________________

By signing this form, you acknowledge that Sheboygan County Department of Health and Human Services has given you a copy of its Notice of Privacy Practices Regarding Health Information, which explains how your health information will be handled in various situations. All clients receiving services on or after April 14, 2003 will be asked to sign this form.

If your first date of service with Sheboygan County Department of Health and Human Services was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as possible after the emergency.

By my signature below, I acknowledge I have received a copy of the Sheboygan County Department of Health and Human Services' Notice of Privacy Practices Regarding Health Information and have been given an opportunity to discuss my concerns and questions.

I understand Sheboygan County Health and Human Services may bill Forward Health, Medicare, or any other 3rd party insurance company for billable services.

______________________________ ______________
Client's Signature Date

Sheboygan County Department of Health and Human Services staff should complete if Acknowledgement Form is not signed:

1. Was the client given a copy of the Notice of Privacy Practices regarding Health Information?

   Yes No

2. Please explain why the client did not sign this acknowledgement form and explain Sheboygan County Department of Health and Human Services' efforts in trying to obtain the client's signature

______________________________ ______________
Employee's Signature Date

SHEBOYGAN COUNTY
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT CENTER

INFORMED CONSENT FOR TREATMENT

Welcome!

Please review the following information about your treatment and rights as a consumer of services at our Clinic.

Following an initial assessment, your assigned provider will discuss with you (and your guardian/representative):

1. Results of the assessment
2. Treatment alternatives
3. Possible outcomes and side effects of treatment recommended in the treatment plan
4. Treatment recommendations and benefits of the treatment recommendations
5. Approximate duration and desired outcome of treatment recommended in the treatment plan
6. Your rights as a consumer receiving outpatient mental health services, including your rights and responsibilities in the development and implementation of an individual treatment plan
7. The outpatient mental health services that will be offered under the treatment plan
8. The fees that you or the responsible party will be expected to pay for the proposed services
9. How to use the clinic's grievance procedure under Chapter DHS 94
10. How to access emergency mental health services during periods outside the normal operating hours of the clinic
11. The clinic's discharge policy, including circumstances under which a consumer may be involuntarily discharged for inability to pay or for behavior not reasonably the result of mental health symptoms

Client Rights
All individuals receiving services at Sheboygan County Mental Health & Substance Abuse Treatment Center have the following rights under Wisconsin State Statutes (51.61, 51.30) and the Wisconsin Administrative Code (HFS 94 & 92).

1. To be treated with dignity and respect.
2. To have staff make fair and reasonable decisions about your treatment and care.
3. To be free from unfair treatment due to your race, national origin, gender, age religion, sexual orientation, or disability.
4. To be free from being filmed, taped, or photographed without your written consent.
5. To prompt, adequate treatment appropriate for your condition, within the limits of available funding.
6. To be informed of your treatment and care, including alternatives to and possible side effects of treatment, including medications.
7. To be allowed to participate in treatment planning.
8. To not receive treatment, including medication, without your written informed consent.
9. To not be given unnecessary or excessive medication.
10. To not be subject to drastic treatment measures or experimental research without your written informed consent.
11. To receive information in writing of any costs of treatment.
12. To be treated in the least restrictive manner and setting necessary to achieve your treatment goals.

Please Review the Following Statements and Indicate Agreement with Your Signature:

I have reviewed and understand the information about my treatment provided as well as my rights as a consumer of services at the Mental Health & Substance Abuse Treatment Center.

I give my consent for treatment at Sheboygan County Mental Health & Substance Abuse Treatment Center.

Client Signature: ______________________________________ Date: _______________

Guardian Signature: ____________________________________ Date: _______________

SHEBOYGAN COUNTY

Health and Human Services Department

Receipt of Client Rights & Grievances Brochure

By signing this form, I acknowledge receipt of the Sheboygan County Health & Human Services brochure on Client Rights & Grievances Procedures and acknowledge that those rights and procedures have been explained to me.

The brochure on Client Rights & Grievances provides information about your personal and treatment rights, record privacy and access, our department's grievance procedure, and your right of access to the courts.

We encourage you to review it carefully. The Client Rights & Grievances brochure is subject to change. If the brochure is changed, you may obtain a revised copy by visiting our website at http://www.sheboygancounty.com/government/departments-f-q/health-and-human-services or by requesting one from our staff.

I acknowledge receipt of the Sheboygan County Health & Human Services brochure on Client Rights & Grievances Procedures.

Signature: ______________________________ Date: ______________

(Client/Parent/Guardian)

Signature: ______________________________ Date: ______________

(Case Manager/Social Worker)

Telephone (920) 459-3207
or 1 (800) 596-1919
Facsimile (920) 459-4353

Health and Human Services Building
1011 North 8th Street
Sheboygan, WI 53081

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