See MHS 149 Legend instructions to complete this form.

*Admission Program Name:

*Admission Program RU:

*Client Date of Birth: - -

SSN: - -

*Date of Admission: - -

*CIN:

*Gender: Female Male Other Unknown

Client's Home Phone: - -

Client's Work Phone: - -

*Client's Address-Street:

*City, Zip & State:

Maiden Name:

3. Alias:

1. Birth Name (Last):

4. Birth Name (First):

2. Mother's First Name:

Assigned Staff #:

5. Presenting Problem-Primary:

10. Education:

15. Special Population:

19. CSI Ethnicity

6. Client Living Arrangements:

11. Employment Status:

16. Legal Class Admission:

20. Client Race:

7. Disabilities:

12. Fiscally Responsible County:

17. District /Site Code:

21. Admission Necessity Code:

8. Marital Status:

13. Place of Birth (County):

18. Preferred Language:

22. Conservatorship/ Court Status:

9. Primary Language: ***

14. Place of Birth (State):

23. Caregiver (Number of children less than 18 years old client responsible for at least 50% of the time):

Caregiver (Number of adults 18 years or older client responsible for at least 50% of the time):

24. Diagnosis: CURRENT DIAGNOSIS USING DSM-5
List Primary Mental health diagnosis first.

ICD-9 Code	ICD-10 Code	
		P

25. Trauma: Y N Unknown

26. Substance Abuse/Dependence: Y N Unknown/Not Reported

Substance Abuse Diagnosis:

27. Diagnosing Practitioner #:

28. General Medical Condition Summary Code:

***IF SONOMA COUNTY DID NOT CONTRACT WITH YOU TO COMPLETE ASSESSMENTS, LEAVE BOXES 24 THROUGH 28 BLANK.

COUNTY OF SONOMA
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

CLIENT EPISODE ADMISSION

Client Name:

Client #: