



Jackson Services Facesheet

Today's
Date: _____

Legal Name <i>(Last, First, M.I.):</i>	DOB:	Age:	Birth Sex:	Gender:
Affirmed Name:	Pronouns:			
Preferred Language? Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	SS#:			
Your Name/Relationship to individual seeking Services:	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown			
Physical Street Address: City: _____ State: _____ Zip: _____	Mailing Address: (If different then physical) <input type="checkbox"/> FE _____ State _____ Zip: _____			
Landline Phone: _____ <input type="checkbox"/> Detailed Message <input type="checkbox"/> Detailed Text Youth Cell Phone: _____ <input type="checkbox"/> Detailed Message <input type="checkbox"/> Detailed Text Guardian Cell Phone: _____ <input type="checkbox"/> Detailed Message <input type="checkbox"/> Detailed Text <small>Checking the boxes above allows Kairos staff to leave detailed voicemails and send detailed text messages.</small>	Phone Number for Reminder Calls: Voice Reminders: _____ Text Reminders: _____ Youth Email:			
Responsible Party(Parent or Legal Guardian): Name: _____ Street Address: _____ City: _____ State: _____ Zip: _____ Relationship: _____ Phone #: _____ Email: _____	Responsible Party(Parent or Legal Guardian): Name: _____ Street Address: _____ City: _____ State: _____ Zip: _____ Relationship: _____ Phone #: _____ <input type="checkbox"/> mail: _____			
Emergency Contact: (outside of household) Name: _____ Relationship: _____ Phone #: _____	Highest Grade Completed: _____ <input type="checkbox"/> Currently a Student School District: _____ School Name: _____			

*Kairos has permission to ID incase of emergency _____ (Initial)

Health Insurance (Check all that apply): **I.D Verified** **No I.D Available**

- AllCare: 740 SE 7th Street, Grants Pass, OR 97527 Phone (541)471-4106 Fax (541)471-4128
 - Jackson Care Connect: 33 N Central Avenue, Medford, OR 97501 Phone (855)722-8208 Fax(503)416-3723
 - Medicaid Open Card or Other: Card Number: _____
 - Medicare Card Number: _____
 - Private Insurance: Name: _____ ID#: _____
 - Group Number: _____ Subscriber Name: _____
 - None
- *We currently only accept those covered by Medicaid with AllCare or Jackson Care Connect as their CCO. There is no copay for Medicaid members and you will not be charged for any services.

- Youth Race:**
- White
 - Alaska Native
 - American Indian
 - Black/African American
 - Asian
 - Native Hawaiian/Pacific Islander
 - Other Single Race
 - Two or more unspecified races

- Youth Ethnicity:**
- Puerto Rican
 - Mexican
 - Cuban
 - Hispanic-Other origin
 - Hispanic-No specific origin
 - Not Hispanic

- Youth Tribal Status:**
- None/Not Applicable
 - Burns Paiute Tribe
 - Confederated Tribes of Coos, Lower Umpqua and Siuslaw
 - Confederate Tribes of Grand Ronde
 - Confederated Tribes of Siletz
 - Confederated Tribes of the Umatilla
 - Confederated Tribes of Warm Springs
 - Coquille Indian Tribe
 - Cow Creek Band of Umpqua Indians
 - Klamath Tribe
 - Other

- Youth Marital Status:**
- Never Married
 - Married
 - Separated
 - Divorced
 - Widowed

- Youth Employment Status:**
- Full Time (35 hours or more per week)
 - Part Time (Less than 35 hours per week)
 - Unemployed
 - Homemaker
 - Student
 - Retired
 - Disabled
 - Unable to work due to being in a hospital or institution
 - Volunteer
 - Sheltered/non-competitive
 - Not working and not looking for work

- Youth Legal Status:**
- 30 Day Civil Commitment
 - 180 Day Civil Commitment
 - Incarcerated
 - Parole
 - Probation
 - Psychiatric Security Review Board (PSRB)
 - Juvenile Psychiatric Security Review Board (JPSRB)
 - Guardianship (Court)
 - Guardianship (Child Welfare)
 - Aid and Assist
 - None
 - Involuntary Custody
 - Pre-Arrest Jail Diversion
 - Post-Arrest Jail Diversion
 - Unknown
 - Voluntary
 - Hold
 - 14 Day Diversion
 - Mental Health Court
 - DUII Diversion
 - DUII Conviction

- Youth Living Arrangement:**
- Other Private Residence
 - Private Residence at home alone or with immediate family
 - Private Residence with relatives non-parental adults or other relatives
 - Private Residence without relatives
 - Foster Home
 - Transient/Homeless
 - Secure Residential Facility
 - Residential Facility
 - Jail
 - Room and board
 - Supported Housing
 - Supportive Housing Scattered
 - Alcohol and Drug Free Housing

- Youth Arrests:**
- Total Arrests in last 30 days:
- None
- Total Arrests in lifetime:
- None
- Total DUII Arrests in last 30 days:
- None
- Total DUII Arrests in lifetime:
- None

Household Income Information:

Annual Gross Household Income: \$ _____

Number of People in Household: _____

Number in each age group dependent on household income:

Individuals under 18: _____

Household Source and Amount of Income:

- Wages/Salary \$_____
- Retirement/Pension/Social Security Income:\$_____
- Other (Alimony/Child Support, Care of foster child: \$_____
- Unknown:\$_____
- Public Assistance: \$_____
- Disability/Social Security Disability: \$_____
- None(no source of income for household)

Youth Veterans Status:

- Veteran with current or former active duty military
- Current or former guard/reserve with active duty
- Current or former guard/reserve with no active duty
- No Military service

Religious Preference:_____

Referred By:

Briefly describe what brought you here today:

Youth Signature (14 and over)

Date

Parent/Guardian Signature

Date

Kairos Staff Only

Input Recieved By :

Date :



Jackson Services
10 Crater Lake Ave
Medford, Oregon 97504
Office (541) 772-0127
Fax (541) 772-0966

□

□

Walk-in Hours

□

Tuesday and Wednesday – 12:00pm to 3:00pm

□

Thursday and Friday – 8:00am to 3:00pm

Crisis- Please call Jackson County
Mental Health at 541-774-8201

Emergency – 911



**Admission Consent and Release Form
Jackson Services**

Youth's Name: _____

D.O.B.: _____ Admission Date: _____

Youth's Preferred Language: _____

Consent to Treatment

I/we, the undersigned, as responsible party(ies), hereby request services for the above named youth with Kairos, and consent to their care and treatment as recommended and provided by the their Care Team.

Youth if 14 or over

Date

Parent or Guardian

Date

Kairos Representative

Date

Agreement to Participate in Treatment and Aftercare

I/we, the undersigned, as responsible party(ies) hereby agree to participate in the treatment of the above named youth while s/he is in the care of Kairos.

Youth if 14 or over

Date

Parent or Guardian

Date

I have an Advanced Health Directive.

It is located at: _____

I do not have an Advanced Directive but would like information and assistance in creating one.

I do not have an Advanced Directive and do not wish to establish one at this time. I understand that any time I determine that I would like to create one, a Kairos representative will be made available to help me do so.

I have a Declaration for Mental Health Treatment.

It is located at: _____

I do not have a Declaration for Mental Health Treatment but would like information and assistance in creating one.

I do not have a Declaration for Mental Health Treatment and do not wish to establish one at this time. I understand that any time I determine that I would like to create one, a Kairos representative will be made available to help me do so.

KAIROS Health History—Jackson Services

In order to obtain a complete picture of you, we need some information about your health history and current health status. Please complete as much information as you know about the following.

Name of PCP: _____ <input type="checkbox"/>	Clinic Name: _____ <input type="checkbox"/>
Date of last visit: _____ <input type="checkbox"/>	Phone Number: _____ <input type="checkbox"/>
Dentist Name: _____ <input type="checkbox"/>	<input type="checkbox"/> _____ a <input type="checkbox"/> e <input type="checkbox"/> _____ <input type="checkbox"/>
Date <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> last visit <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____ <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> e <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> er <input type="checkbox"/> _____ <input type="checkbox"/>
Date of last hearing exam: _____ <input type="checkbox"/>	
Date <input type="checkbox"/> <input type="checkbox"/> last eye exam: _____ <input type="checkbox"/>	
Mental Health Provider: _____ <input type="checkbox"/>	Clinic Name: _____ <input type="checkbox"/>
Date <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> last visit <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____ <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> e <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> er <input type="checkbox"/> _____ <input type="checkbox"/>

Do you have a history of self-harm or attempted suicide? no yes

Please list the date(s) and describe:

Do you have a history of harming other people or animals? no yes

Please list the date(s) and describe:

Do you have any environmental allergies? no yes

Please list and note what type of reaction occurs: _____

Are you allergic to any medications? no yes

Please list and note what type of reaction occurs: _____

Are you currently taking any medications? no yes

Name of Medication	Dosage and Instructions	Prescribing Provider
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		

Pharmacy Name: _____ <input type="checkbox"/>	Location: _____ <input type="checkbox"/>
<input type="checkbox"/> Phone Number: _____ <input type="checkbox"/>	<input type="checkbox"/>

Do you have any other health concerns that you feel we should know about? Please explain:

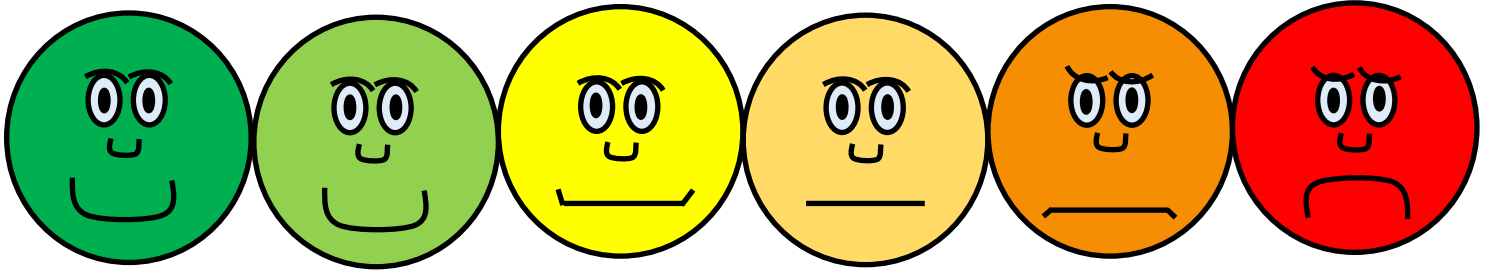
Please select any of the following that you have experienced in the last 30 days: None

Eyes	<input type="checkbox"/>	Blurred Vision <input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Seeing Double? <input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Seeing Halos? <input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Eye Pain <input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Watering?	<input type="checkbox"/>
	<input type="checkbox"/>	Itchi <input type="checkbox"/>	
	<input type="checkbox"/>	Wear Glasses/Contacts?	
Ears	<input type="checkbox"/>	Difficulty Hearing?	
	<input type="checkbox"/>	Buzzing or Ringing? <input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Frequent Earaches/Infections <input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Motion Sickness?	
	<input type="checkbox"/>	Drainage?	
	<input type="checkbox"/>	Use Hearing Aid(s)?	
Nervous Systems	<input type="checkbox"/>	Numbness/Tingling?	<input type="checkbox"/>
	<input type="checkbox"/>	Trembling/Shaking?	
	<input type="checkbox"/>	Fainting Spells?	
	<input type="checkbox"/>	Changes in Handwriting <input type="checkbox"/>	
	<input type="checkbox"/>	Speech Difficulty? <input type="checkbox"/>	
	<input type="checkbox"/>	Loss of Muscle Strength <input type="checkbox"/>	
	<input type="checkbox"/>	History of Seizures?	
	<input type="checkbox"/>	Date of last Seizure?	
Digestive	<input type="checkbox"/>	Frequent Indigestion	
	<input type="checkbox"/>	Heartburn	
	<input type="checkbox"/>	Frequent Bloating	
	<input type="checkbox"/>	Bloated Stomach	
	<input type="checkbox"/>	Loss of Appetite	
	<input type="checkbox"/>	Nausea or Vomiting	
	<input type="checkbox"/>	Spit up Blood	
	<input type="checkbox"/>	Constipation	
	<input type="checkbox"/>	Diarrhea	
	<input type="checkbox"/>	Black/Grey/Blood Stools	
	<input type="checkbox"/>	Rectal Pain	
	<input type="checkbox"/>	Rectal Bleeding	
	<input type="checkbox"/>	Change in Stools	
General	<input type="checkbox"/>	Always Tired	
	<input type="checkbox"/>	Trouble Sleeping	
	<input type="checkbox"/>	Often Crying	
	<input type="checkbox"/>	Depressed	
	<input type="checkbox"/>	Hopeless Outlook	
	<input type="checkbox"/>	Considered Suicide	
	<input type="checkbox"/>	Loss Temper Often	
	<input type="checkbox"/>	Trouble Relaxing	
	<input type="checkbox"/>	Anxiety	
	<input type="checkbox"/>	Work/Family Problems	
	<input type="checkbox"/>	Change in Memory/Concentration	
	<input type="checkbox"/>	Sexual Difficulty/Problems	
	Head & Neck	<input type="checkbox"/>	Frequent Headaches?
<input type="checkbox"/>		Migaines?	
<input type="checkbox"/>		Neck Pains?	
<input type="checkbox"/>		Lumps or Swelling?	
<input type="checkbox"/>		Difficulty Swallowing?	
Other?	<input type="checkbox"/>		

Pain Screening:

What is **your current physical pain level?**

Please mark the one most accurate number (0-10) on the scale below.



No Hurt

Hurt a Little

Hurts Little More

Hurts Even More

Hurts Whole Lot

Hurts Worst



Where is this pain located? Head Arms Legs Back Hands
 Feet Ankles Knees Other: _____

What caused the pain? _____

Form completed by: _____

Print Name

Sign Name

Relationship to Youth

Date

Kairos Representative Reviewing Form:

Print Name

Sign Name

Title

Date

Recommended follow-up with Primary Care Provider: Yes No



Youth and Family Information Attestation Jackson Services

Youth Name

DOB

I/we the undersigned have been informed and received the following information regarding services provided by Kairos. Please initial in the lines provided:

- _____ After-Hours Crisis Support Information
- _____ Notice of Privacy Practices
- _____ Abuse Reporting Guideline
- _____ Confidentiality Policy
- _____ Client and Family Rights
- _____ Voter Registration Information
- _____ Grievance Procedure "Have A Problem Or A Complaint?"
- _____ Behavior Support Philosophy
- _____ Feedback Informed Treatment (FIT) and OpenFIT Use Disclaimer
- _____ Home Safety Service Delivery Agreement
- _____ Video Surveillance Acknowledgement
- _____ Attendance Policy

Youth if 14 or over (Print Name)

Signature

Date

Parent and/or Legal Guardian (Print Name)

Signature

Date

KAIROS Representative (Print Name)

Signature

Date

Youth refused to sign for the receipt of the above documents, however copies of all the above guidelines were given to the youth and/or parent/legal guardian _____ (Kairos Representative)