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NEW YORK STATE | Office of Mental Health

Patient Characteristics Survey for the week ending **10/26/2025**

Sheet Number: _____

EHR ID: _____

1. Unit Code: _____ **2. Site Code:** _____

3a. Client's First Name: _____ **3b. Client's Last Name:** _____

4. Date of Birth *(MMDDYYYY format)*

5. Sex on Birth Certificate *(select one)*

❍ Male ❍ Female ❍ X (Non-Binary) ❍ Intersex ❍ Unknown or missing

6. Gender (*select one*)

❍ Cisgender
❍ Transgender Woman
❍ Transgender Man
❍ Non-Binary
❍ Gender Non-Conforming
❍ Two-Spirit (If Client is American Indian or Alaskan Native)
❍ Other
❍ Client declined
❍ Unknown or missing

7. Sexual Orientation *(select one)*

❍ Straight
❍ Lesbian or gay
❍ Bisexual
❍ Two-Spirit (If Client is American Indian or Alaskan Native)
❍ Other
❍ Client declined
❍ Unknown or missing

8a. Hispanic Ethnicity *(select one)*

❍ No, not Hispanic/Latino ❍ Yes ❍ Unknown or missing

8b. If Yes to question 8a, select one of the following:

❍ Central American ❍ Mexican ❍ South American ❍ Unknown or missing
❍ Cuban ❍ Other Caribbean ❍ Spaniard ❍ Not Applicable
❍ Dominican ❍ Puerto Rican ❍ Other

9. Race *(select all that apply)*

☐ a. White
☐ b. Black/African American
☐ c. Asian
☐ d. American Indian/Alaska Native
☐ e. Native Hawaiian/Other Pacific Islander
☐ f. Other
☐ g. Unknown or missing

9h. If 9b. Black/African American is selected, select one of the following:

❍ African American ❍ African Continent ❍ Unknown or missing
❍ Afro-Caribbean ❍ Other Black ❍ Not Applicable

Sheet Number: _____	**Client's Name:** _____

9i. If 9c. Asian is selected, select one of the following:

❍ Asian Indian	❍ Filipino	❍ Laotian	❍ Taiwanese	❍ Unknown or missing
❍ Bangladeshi	❍ Hmong	❍ Malaysian	❍ Thai	❍ Not Applicable
❍ Burmese	❍ Indonesian	❍ Nepalese	❍ Tibetan	
❍ Cambodian	❍ Japanese	❍ Pakistani	❍ Vietnamese	
❍ Chinese	❍ Korean	❍ Sri Lankan		

9j. If 9e. Native Hawaiian/ Other Pacific Islander is chosen, select one of the following:

❍ Chamorro	❍ Guamanian	❍ Samoan	❍ Other Pacific Islander
❍ Fijian	❍ Native Hawaiian	❍ Tongan	❍ Unknown or missing
			❍ Not Applicable

10. Living Situation *(select one)*
*(Inpatient programs, Crisis Resident (CR), and short-term inpatient setting should report residence **before** admission)*

- ❍ Private residence *(home, apartment, rooming house)*
- ❍ Inpatient setting or children's Residential Treatment Facility (RTF)
- ❍ OMH Residential Care, **Licensed** programs, community residence (child or adult), crisis residence, family care, teaching family home, apartment treatment, congregate treatment, apartment support, congregate support, community residence – SRO
- ❍ Adult home *(Department of Health (DOH) licensed residential program for adults)*
- ❍ Agency-operated Boarding Home through Department of Social Services/Administration for Children's Services (DSS/ACS) *(Foster Home)*
- ❍ Institutional setting for youth: Office of Children and Family Services (OCFS) Juvenile Justice Facility
- ❍ Institutional setting for youth: OCFS Residential Treatment Center (RTC) / Qualified Residential Treatment Program (QRTP)
- ❍ Youth community-based residence *(OCFS, DSS/ACS)*
- ❍ Nursing or health-related facility *(nursing home, skilled nursing facility)*
- ❍ Homeless *(Economic hardship "doubled-up", Shelter, Hotel or Motel, Car, Park, Bus Station, Train Station, Campsite, Transitional Housing, Transient Housing, or Other temporary living situation)*
- ❍ Incarcerated
- ❍ *Permanent Supportive Housing (Supported Single Room Occupancy (SRO), Scattered-Site supportive housing, Shelter Plus Care housing)*
- ❍ Other *(e.g., non-OMH residential care such as group home or halfway house) Individualized Residential Alternative (IRA)*
- ❍ Unknown or missing

11. If living in private residence, what is the household composition *(select all that apply – Inpatient programs and Residential Treatment Facilities should report household composition **before** admission)*

☐ Client lives alone	☐ Other relatives of client not specified above
☐ Client's child, stepchild, foster child, grandchild	☐ Foster parent
☐ Client's parent (biological, adoptive, stepparent)	☐ Other people unrelated to client
☐ Client's sibling(s)	☐ Unknown or missing
☐ Client's spouse or domestic partner	☐ Not Applicable

Sheet Number: _____	**Client's Name:** _____

12. Parental Status *(select all that apply)*

- ☐ No children
- ☐ Has children over 18 years old
- ☐ Has minor children, in client's custody
- ☐ Has minor children, NOT in client's custody
- ☐ Expectant parent
- ☐ Unknown or missing

13. Was client homeless in shelter or on the street at any time within the past 6 months?
(Economic hardship "doubled-up", Shelter, Hotel or Motel, Car, Park, Bus Station, Train Station, Campsite, Transitional Housing, or other temporary living situation)

❍ No ❍ Yes ❍ Unknown or missing

14. County of Residence **15. Residence Zip Code**
*(Inpatient programs and Residential Treatment Facilities should report residence **before** admission)*

16. Preferred Language *(select one)*

- ❍ English
- ❍ Spanish/Spanish Creole
- ❍ Russian
- ❍ Mandarin
- ❍ Cantonese
- ❍ Fujianese
- ❍ Other Chinese
- ❍ French
- ❍ French/Haitian Creole
- ❍ Portuguese/Creole
- ❍ Italian
- ❍ Polish
- ❍ Yiddish, Pennsylvania Dutch/ other West Germanic
- ❍ Hebrew
- ❍ Arabic
- ❍ Hindi
- ❍ Urdu
- ❍ Other Indic (e.g., Sindhi)
- ❍ Other Indo-European
- ❍ African Languages
- ❍ Tagalog
- ❍ Korean
- ❍ Vietnamese
- ❍ Other Asian
- ❍ Sign Language
- ❍ Other
- ❍ Unknown or missing

17. Does client have prior or current active U.S. military service?

❍ No ❍ Yes ❍ Unknown or missing

18. Employment Status *(select one - select the first outcome that applies)*

- ❍ Employed (Competitive or Self-employed)
- ❍ Other employment (internship, OMH funded employment, etc.)
- ❍ Non-paid work position (volunteer)
- ❍ Unemployed and looking for work
- ❍ Not In Labor Force: unemployed but not looking for work, retired, homemaker, student, incarcerated, or psychiatric inpatient, underage of employment/ below working age
- ❍ Unknown or missing

19. If employed, what are the client's usual hours worked per week? *(select one)*

- ❍ 1-14 hours
- ❍ 15-34 hours
- ❍ 35 hours or more
- ❍ Unknown or missing
- ❍ Not Applicable

20. Has client attended school (in person or virtual), home tutoring, or received education instruction at any time in the past three months?

❍ No ❍ Yes ❍ Unknown or missing

Sheet Number: _____	**Client's Name:** _____

21. Education Level *(select one)*

- ❍ No formal education
- ❍ Pre-Kindergarten
- ❍ Kindergarten
- ❍ First grade
- ❍ Second grade
- ❍ Third grade
- ❍ Fourth grade
- ❍ Fifth grade
- ❍ Sixth grade
- ❍ Seventh grade
- ❍ Eighth grade
- ❍ Ninth grade
- ❍ 10th grade
- ❍ 11th grade
- ❍ 12th grade, no diploma
- ❍ High school diploma or GED
- ❍ Vocational and/or trade school
- ❍ Some college, no degree
- ❍ Associate's degree
- ❍ Bachelor's degree
- ❍ Graduate degree
- ❍ Other
- ❍ Unknown

22. Does the child have an IEP for special education services through the school district's Committee on Special Education?

- ❍ No
- ❍ Yes
- ❍ Unknown or missing
- ❍ Not applicable

23. Comorbidities *(select all that apply)*

a. Mental Illness or Emotional Disturbance	❍ No	❍ Yes	❍ Unknown or missing
b. Intellectual and Developmental Disability	❍ No	❍ Yes	❍ Unknown or missing
c. Autism Spectrum Disorder	❍ No	❍ Yes	❍ Unknown or missing
d. Other Developmental Disability (Epilepsy, Cerebral Palsy, Neurological Impairment)	❍ No	❍ Yes	❍ Unknown or missing
e. Alcohol Use Disorder	❍ No	❍ Yes	❍ Unknown or missing
f. Cannabis Use Disorder	❍ No	❍ Yes	❍ Unknown or missing
g. Tobacco Use Disorder	❍ No	❍ Yes	❍ Unknown or missing
h. Opioid Use Disorder	❍ No	❍ Yes	❍ Unknown or missing
i. Other Drug/Substance Use Disorder	❍ No	❍ Yes	❍ Unknown or missing
j. Mobility Impairment	❍ No	❍ Yes	❍ Unknown or missing
k. Hearing Impairment	❍ No	❍ Yes	❍ Unknown or missing
l. Visual Impairment	❍ No	❍ Yes	❍ Unknown or missing
m. Speech Impairment	❍ No	❍ Yes	❍ Unknown or missing
n. Major Neurocognitive Disorder (Alzheimer's Disease or dementia) of any subtype	❍ No	❍ Yes	❍ Unknown or missing

Sheet Number: _____	**Client's Name:** _____

24. Chronic Medical Condition *(select all that apply)*

a.	Hyperlipidemia (High blood fat/High cholesterol)	❍ No	❍ Yes	❍ Unknown or missing
b.	High Blood Pressure	❍ No	❍ Yes	❍ Unknown or missing
c.	Diabetes	❍ No	❍ Yes	❍ Unknown or missing
d.	Obesity [based on BMI* or unknown]	❍ No	❍ Yes	❍ Unknown or missing
e.	Coronary Vascular Disease	❍ No	❍ Yes	❍ Unknown or missing
f.	Cerebrovascular Disease	❍ No	❍ Yes	❍ Unknown or missing
g.	Other Cardiac Condition	❍ No	❍ Yes	❍ Unknown or missing
h.	Pulmonary (Chronic Obstructive Pulmonary Disease (Emphysema), Asthma)	❍ No	❍ Yes	❍ Unknown or missing
i.	Kidney Disease (dialysis, chronic renal failure, kidney stones)	❍ No	❍ Yes	❍ Unknown or missing
j.	Liver Disease (Cirrhosis, Hepatitis A/B/C, alcohol-related liver injury)	❍ No	❍ Yes	❍ Unknown or missing
k.	Endocrine Condition (e.g., hyper- or hypothyroidism; adrenal insufficiency or hypercortisolism; or hyperprolactinemia)	❍ No	❍ Yes	❍ Unknown or missing
l.	Progressive neurological condition (Multiple Sclerosis, Cerebral palsy, Amyotrophic lateral sclerosis (ALS))	❍ No	❍ Yes	❍ Unknown or missing
m.	Traumatic Brain Injury	❍ No	❍ Yes	❍ Unknown or missing
n.	Joint and connective tissue disease (Lupus, Rheumatoid arthritis, Osteoporosis, Osteoarthritis)	❍ No	❍ Yes	❍ Unknown or missing
o.	Cancer	❍ No	❍ Yes	❍ Unknown or missing
p.	Long COVID-19	❍ No	❍ Yes	❍ Unknown or missing
q.	Other chronic medical condition(s) not listed above	❍ No	❍ Yes	❍ Unknown or missing

25. In the last 12 months, did client use cannabis (marijuana, weed, pot or hashish)?

❍ No ❍ Yes ❍ Unknown or missing

26a. In the last 12 months, did client smoke cigarettes, vape or use tobacco products?

❍ No ❍ Yes ❍ Unknown or missing

26b. Did client receive a medication for treatment of tobacco use disorder (e.g. varenicline, bupropion, nicotine replacement therapy) from this program in the past year?

❍ No ❍ Yes ❍ Unknown or missing

26c. Did client receive counseling or psychotherapy for treatment of tobacco use disorder from this program in the past year?

❍ No ❍ Yes ❍ Unknown or missing

27a. In the last 12 months, did client receive any medications for Alcohol Use Disorder (e.g., naltrexone, acamprosate, disulfiram) from this program?

❍ No ❍ Yes ❍ Unknown or missing

27b. In the last 12 months, did the client receive any psychotherapy or counseling for alcohol use disorder from this program?

❍ No ❍ Yes ❍ Unknown or missing

Sheet Number: _____	**Client's Name:** _____

28a. In the last 12 months, did client receive any medications for opioid use disorder (e.g., long-acting naltrexone, buprenorphine) from this program?
❍ No ❍ Yes ❍ Unknown or missing

28b. In the last 12 months, did the client receive any counseling or psychotherapy for opioid use disorder from this program?
❍ No ❍ Yes ❍ Unknown or missing

29. In the last 12 months, did client receive any treatment for any other Addiction Disorder from this program?
❍ No ❍ Yes ❍ Unknown or missing

30. In the last 12 months, was the client screened for Hepatitis C?
❍ No ❍ Yes ❍ Unknown or missing

31. In the past 12 months, did the client have any suicidal thoughts?
❍ No ❍ Yes ❍ Unknown or missing

32. In the past 12 months, did the client have a suicide attempt?
❍ No ❍ Yes ❍ Unknown or missing

33. Does client have a Serious Mental Illness/Serious Emotional Disturbance?
❍ No ❍ Yes ❍ Unknown or missing

34. Primary Psychiatric Diagnosis

35. Additional Diagnosis

36. Cash Assistance Benefits *(select all that apply)*

a. SSI (Supplemental Security Income)	❍ No	❍ Yes	❍ Unknown or missing
b. SSDI (Social Security Disability Insurance)	❍ No	❍ Yes	❍ Unknown or missing
c. Veteran's disability benefits	❍ No	❍ Yes	❍ Unknown or missing
d. Veteran's Cash Assistance	❍ No	❍ Yes	❍ Unknown or missing
e. Public Assistance Cash Program (TANF, Safety Net, etc.)	❍ No	❍ Yes	❍ Unknown or missing
f. Other cash benefits (pension, SSA retirement, other)	❍ No	❍ Yes	❍ Unknown or missing

37. Is the client currently covered by health insurance? ❍ No ❍ Yes ❍ Unknown or missing

38. Health Insurance Coverage
If **Yes** to 37, please indicate the type(s) of health insurance coverage:

a. Medicaid	❍ No	❍ Yes	❍ Unknown or missing	
b. If **Yes** to 38a, is it Managed Care?	❍ No	❍ Yes	❍ Unknown or missing	❍ Not applicable
c. Medicare	❍ No	❍ Yes	❍ Unknown or missing	
d. Private Insurance	❍ No	❍ Yes	❍ Unknown or missing	
e. Child Health Plus	❍ No	❍ Yes	❍ Unknown or missing	
f. Other Health Insurance	❍ No	❍ Yes	❍ Unknown or missing	

Sheet Number: _____	**Client's Name:** _____

39. Criminal Justice or Juvenile Justice Status *(select one - select the **current status** that applies).*

- ❍ None
- ❍ Criminal Procedure Law (CPL) 330.20
- ❍ Article 10-Sex Offender Management & Treatment (SOMTA)
- ❍ NYS Dept. of Correctional Services Prisoner
- ❍ County/City Jail, Court Detention or Police Lockup Prisoner (including CPL 730 and CL 508 referrals)
- ❍ Parolee (adults)
- ❍ Probationer (adults)
- ❍ PINS (Person in Need of Supervision)
- ❍ Adjudicated Juvenile Delinquent or Offender
- ❍ Alternative to Incarceration (ATI) status, Mental Health Court, Court Diversion, Drug Court Treatment
- ❍ Other criminal justice status
- ❍ Unknown whether or not client has a criminal justice or juvenile justice status

40. Admission Date, Current Episode (If the program does not have an admission date, then Date of Intake is acceptable) *(MMDDYYYY format)*

Date: ☐

- ❍ Check here if program **does not do** formal admission paperwork.
- ❍ Check here if **unknown** admission date.

41. Date Last Served Before 10/20/2025 by *this* Program *(MMDDYYYY format)*

Date: ☐

- ❍ Check here if client was **never** before served by this program.
- ❍ Check here if client's date last served is **unknown.**

42. Date of Client Service *(select all that apply)*

☐ Oct 20 ☐ Oct 21 ☐ Oct 22 ☐ Oct 23 ☐ Oct 24 ☐ Oct 25 ☐ Oct 26