Southeast Kansas Mental Health Center

# Face Sheet

ADAS __Yes __ No ____%
DX _____
For CA Staff Use Only

Date _____ E-mail _____ Case No. _____

Name _____ Date of Birth _____ Age _____

Social Security # _____ Military/Veteran Status ☐ Yes ☐ No

Females Only: Maiden name _____ Former married names _____

Address _____ City/State/Zip _____

Phone # _____ Work Phone # _____

Cell Phone # _____ County of residence _____

We may contact you and/or leave a message regarding your appointment times unless instructed otherwise _____

If less than 6 months in this county, please specify previous county of residence _____

Do you have a legal guardian? ☐ No ☐ Yes If Yes, please provide the following:

Legal Guardian _____ Phone # _____

Address _____

Legal Custody Status (check one) ☐ A. No JJA/DCF involvement ☐ D. Child in JJA Custody/out-of-home ☐ G. Child in JJA custody/lives at home ☐ J. Under supervision of JJA/not custody ☐M. Child in DCF custody/out-of-home ☐P. Child in DCF custody/lives-at-home ☐S. Under DCF supervision, not custody ☐ Other- Explain

Employment Status (check one) ☐ 2. Part-time (less than 35 hrs) ☐ 3. Full-time (more than 35 hrs) ☐ 4. Retired ☐ 5. Unemployed ☐ 6. Active Military Duty ☐ 7. Not in labor force

Marital Status (check one) ☐ 1. Never Married ☐ 2. Married ☐ 4. Divorced ☐ 5. Separated ☐ 6. Widowed ☐ 7. Common-law ☐ 00. Other

Student Status (check one) ☐ 1. Full Time Student ☐ 2. Part-time Student ☐ 3. Not a student

School _____

Race (check one) ☐ White ☐ Black or African American ☐ American Indian ☐ Alaskan Native ☐ Native Hawaiian ☐Pacific Islander ☐ Asian ☐ Other

Ethnicity ☐ Hispanic ☐ NOT Hispanic

Primary Language _____ Other languages spoken _____

Primary Care Provider _____ Primary Care Provider Telephone # _____ Referred By _____

Gender (check one) ☐ 1. Male ☐ 2. Female ☐ 3. Transgender male to female ☐ 4. Transgender female to male

Party responsible for account _____ Relationship _____

Social Security # _____ DOB: _____ Email _____

Have you received previous mental health services? ☐ Yes or ☐ No If yes, please list:

| Name of Facility | Address | Inpatient/Outpatient | Dates |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Client Employment Information (if not employed, head of house employment information)

Employee Name _____

Employer _____ Occupation _____

Name (spouse) _____

Employer _____ Occupation _____

Address/City/State/Zip _____ Phone _____

| List sources of household income* | Source | Gross Monthly Amount |
|---|---|---|
| | | |
| | | |
| | | |

* ***Proof of income must be attached for fee adjustment.***

List those dependent upon household income

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Emergency Contact Name _____ Telephone # _____

Address _____

You have the right to use Advance Directives. Please indicate below if you have written Advance Directives,. If not, a form can be provided, but is not required for treatment. ☐ Yes or ☐ No (Advanced Directives are your written health care choices).

Reimbursement Information

PRIMARY INSURANCE (attach copy) _____

ID # _____ Group # _____

Address _____ City _____ State/ZIP _____

Insured's Name _____ DOB _____

Client's relationship to insured _____

Benefit verification date _____ Pre-certification date & info. _____

SECONDARY INSURANCE (attach copy) _____

ID # _____ Group # _____

Address _____ City _____ State/ZIP _____

Insured's Name _____ DOB _____

Client's relationship to insured _____

Benefit verification date _____ Pre-certification date & info. _____

1. Is the patient a Veteran? ☐ Yes ☐ No
   a. Did the VA refer you here for treatment? ☐ Yes ☐ No
   b. Does the patient have a VA "fee basis ID card?" ☐ Yes ☐ No

   Veterans Administration Authorization: Does the patient authorize you to bill the VA? ☐ Yes ☐ No

2. Do you have a Federal Black Lung card? ☐ Yes ☐ No
   Are the services you are receiving today related to lung disease? ☐ Yes ☐ No
   If yes, submit claims to: Federal Black Lung Program, PO Box 740, Lanham, Maryland 20706

3. Is this medical condition due to an accident of any kind? ☐ Yes ☐ No
   If yes, was it: ☐ Work Related ☐ Auto ☐ Injured in own home ☐ Other

WORKER'S COMPENSATION INSURANCE INFORMATION

Date of accident _____ Employer Name and Address _____

Names of Workers Compensation Insurance _____

Name of Person or company Insured _____

Insurance company Claim or Policy # _____

Worker's compensation Claim # _____

Name of Worker's Compensation Agency where claim was filed _____

Address _____

Has the case been settled ☐ Yes Date _____ ☐ No

Name of Patient's Legal Representative in this case (if any) _____

Phone number of Legal Representative _____

AUTOMOBILE, NO-FAULT OR LIABILITY INSURANCE INFORMATION:

Date of Accident: _____ If other than auto, describe accident _____

Business /Property Owner _____ Address: _____ Telephone#: _____

Type of insurance: Premises Medical _____ Liability _____

Name of Policy holder _____ Address of Policyholder _____

Policy Number or Claim ID Number _____ Insurance Company _____

Address of Insurance company _____

Legal Representative& Phone number for this case (if any) _____

Southeast Kansas Mental Health Center

# Agreement for Financial Responsibility

Client _____ Case # _____

| 2019 | | ***Fees are subject to change without notice*** | |
|---|---|---|---|
| Type of Service | | Unadjusted Fee | Adjusted Fee** |
| Assessment (Counselor or QMHP) | 90791 | $ 200.00 per hour | $ |
| Assessment (Psychiatrist) | 90792 | $ 210.00 per hour | $ |
| Individual/Family Therapy (Counselor or QMHP) | 90837 | $ 210.00 per hour | $ |
| Group Therapy | 25000 | $ 90.00 per hour | $ |
| Community Psychiatric Support | 31000 | $ 140.00 | $ |
| Medication Review | 99213 | $ 130.00 per hour | $ |
| Injections | 96372 | $ 40.00 per appointment | $ |
| Targeted Case Management | 34000 | $ 25.00 per unit* | $ |
| Attendant Care | 33000 | $ 10.00 per unit* | $ |
| Psychosocial Group | 32000 | $ 10.00 per unit* | $ |
| Peer Support (Individual) | 35000 | $ 15.00 per unit* | $ |
| Outpatient Treatment Program Chemical Abuse Services | 90837 | $ 210.00* | $ |
| Psychological Evaluation | 14000 | $ 210.00 per hour | XXXX |
| Alcohol/Drug Diagnostic Evaluation | 90791 | $150 per evaluation*** | XXXX |
| Alcohol/Drug Information School (Adult) | 61000 | $100.00*** | XXXX |
| Alcohol/Drug Information School (Adolescent) | 61000 | $50.00*** | XXXX |
| Tobacco Cessation | 90829 | $60.00 | XXXX |
| Tobacco Cessation Class | 25200 | $40.00 | XXXX |

** - A unit is 15 minutes.* *** - Proof of income must be attached before fee is adjusted.* ****-No fee adjustment.*

## PLEASE READ THIS CONTRACT BEFORE SIGNING

I authorize use of this form for all my insurance submissions.
I authorize the Center to act as my agent in helping me obtain payment from my insurance.
I authorize payment directly to the Center for services rendered. I understand that a claim will be filed at the unadjusted cost per hour. If my insurance does not reimburse the Center in the amount of my fee, I understand that I am responsible for my bill.
I authorize the Center to disclose information needed for billing purposes to all my insurance companies. I acknowledge receipt and I have reviewed and understand the Financial Policies. I agree to comply with these policies.
I understand that 24 hours notice is required when canceling or rescheduling my appointment and that missed appointments will be charged at the sliding scale rate.
I certify that I have received the Guide to Services, Welcome brochure, and Notice of Privacy Practices, and Clients Rights.
I certify that I understand my rights and responsibilities.
I certify that I have provided accurate information.
I certify that I have read and agree to this contract.
I certify that the fee was discussed with me.

_____ _____ _____

Client/Parent or Legal Representative Date Witness

PLEASE MAKE COPY FOR CLIENT - ORIGINAL IS FILED IN CASE RECORD

Southeast Kansas Mental Health Center

# Informed Consent For Voluntary Initial Assessment and Treatment

Client Name: _____

I understand that by signing this consent for initial assessment and treatment that I am agreeing to participate in an evaluation at Southeast Kansas Mental Health Center. The purpose of this evaluation is to assess my current mental health or substance abuse needs and to develop specific treatment recommendations related to my concerns that have brought me to the Center.

I understand that the initial evaluation will be conducted by _____.

The evaluation will consist of interviews, but I may also be asked to participate in psychological testing to more thoroughly assess my needs.

I understand that my therapist may need to discuss my case in a confidential manner with a professional associate and/or supervisor for the purpose of providing higher quality service to me. I am aware that I may be asked to see additional professional staff who may participate in my evaluation and treatment. I understand that these discussions will be kept confidential unless I authorize that information be released or unless allowed or required by law. These exceptions to confidentiality are specified in the *Privacy Policy* of which I have been given a copy.

I understand that some treatment recommendations may be addressed during the initial interview(s). Once the evaluation is complete and an initial treatment plan has been formulated, I will be given the opportunity to review and discuss with my therapist my diagnosis and treatment, including alternatives to these recommendations.

I understand that this consent is voluntary and that I can withdraw my consent to treatment at any time.

I understand that some services may be made available through telemedicine and not in person with a provider. I have the right to not have services provided by telemedicine.

I hereby consent to participate in the process of assessment and treatment at Southeast Kansas Mental Health Center.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Signature Date

Southeast Kansas Mental Health Center

# ADULT INTAKE ASSESSMENT[1]

*This information is part of your confidential medical record. Your answers are important to providing the best possible treatment. Please answer as many questions as possible. Mark any questions you prefer to answer in person.*

*Clinician Use Only:* *ID:* _____ *Date:* _____
*Time In/Out:* _____ *Units:* _____
*Intake Assessment Code:* ☐ *ADMN (New) or* ☐ *ADMR (Reopen)*

## IDENTIFYING INFORMATION

Client Name: _____ DOB: _____ Age: _____

☐ Male ☐ Female Height: _____ Weight: _____ lbs.

Distinguishing physical characteristics (i.e., hair color, disabling condition, etc.): _____

_____

Physical Aids Present (i.e., glasses, cane, walker, hearing aid, etc.): _____

_____

Cultural Identity: _____

How long in area? _____ Type of Residence: _____

Who referred you?

☐ self
☐ family member
☐ mental health professional
☐ ad in phone book
☐ agency
☐ Other _____
☐ friend
☐ law enforcement
☐ physician/nurse
☐ minister
☐ co-worker

## PRESENTING PROBLEMS

What is the MOST SIGNIFICANT problem or reason you are seeking help today? _____

_____

How would you rate the severity of this problem? ☐ mild ☐ moderate ☐ significant ☐ extreme

How long have you had this problem? _____

How often does the problem occur? ☐ constantly ☐ daily ☐ weekly ☐ monthly ☐ less often

On the next page are some common problem areas for adults. To help focus on the most important issues, please complete the following checklist.

[1]Adapted from instrument of Western Arkansas Counseling and Guidance Center, Ft. Smith, Arkansas (2005), used with permission.

Has there been:

Suicide thinking or attempts ☐ In the last month? ☐ Today ☐ _____

Thoughts of harming others or attempts ☐ In the last month? ☐ Today ☐ _____

In what ways have the problems troubled you? _____

_____

What do you hope to get from treatment? _____

_____

What do you expect from your treatment team? _____

_____

What do you think your role in treatment will be? _____

Who else, such as family members or friends, will be involved in your treatment? _____

_____

What **problems** or **needs** do you have that might hinder treatment or ability to reach your desired goals?

_____

What **preferences** do you have regarding your treatment program at Southeast Kansas Mental Health Center? For example, is there a service that you do not want?

_____

Is there a court order to receive treatment? ☐ yes ☐ no

## STRENGTHS, ABILITIES, NEEDS & PREFERENCES

What are **three (3)** resources **(strengths)** that will help in your treatment?

| | | |
|---|---|---|
| ☐ Family Support | ☐ Network of Friends | ☐ Spiritual |
| ☐ Employment | ☐ Stable Finances | ☐ Available Transportation |
| ☐ Intelligence | ☐ Good Health | ☐ Other: _____ |

You possess many different **abilities** that can be utilized to help overcome your problems. What are **six (6)** of your abilities that may be most useful in your treatment? I . . .

| | | |
|---|---|---|
| ☐ take medication | ☐ am assertive | ☐ express thoughts and feelings |
| ☐ work cooperatively with others | ☐ provide leadership | ☐ abstain from alcohol/drugs |
| ☐ request help from others | ☐ resolve conflicts | ☐ analyze problems |
| ☐ use self-help materials | ☐ keep appointments | ☐ develop solutions to problems |
| ☐ follow directions | ☐ complete tasks assigned | ☐ manage time effectively |
| ☐ maintain consistent behavior | ☐ other: _____ | ☐ other: _____ |

| DAILY ACTIVITIES[2] | | Mark the following (S) if STRENGTH Or (L) if LIMITATION If neither, leave blank |
|---|---|---|
| 1. Personal Care | Present self as generally clean, e.g., bathes, showers, brushes teeth. | |
| 2. Grooming | Care for general appearance, hair, hands, makeup, shaves. | |
| 3. Dress | Wear clean clothes, in good repair, comfortable for the weather, activity. | |
| 4. Household Stability | Contribute to and maintain stable housing; organize possessions, clean, comply with house rules if living with others. | |
| 5. Physical & Mental Health | Manage or assist with health issues, known health problems, medical appointments, medications as prescribed, weight, mood changes. | |
| 6. Communicates | Listen & respond to people; express feelings, especially anger effectively | |
| 7. Safety within environment | Focus attention: safe vision, hearing, & adequate memory; avoid high-risk places, misuse of knives, matches, razors, appliances, dangerous household substances. | |
| 8. Managing Time | Rarely tardy or absent for work, appointments, adequate task management, follow regular sleep periods, mealtimes. | |
| 9. Managing Money | Manage money wisely, control spending habits and responsible with money; e.g., no thefts, no shoplifting, assists or pays bills on time, etc. | |
| 10. Nutrition | Eat at least 2 nutritious meals, good snacks | |
| 11. Problem Solving | Make decisions; resolve basic problems of daily living; clarify instructions, ask questions for clarity, setting expectations. | |
| 12. Family Relationships | Get along with family, significant others; contribute to positive relationships with spouse, parent, sibling, child, significant other/ family | |
| 13. Alcohol, Drug Use | Avoid misuse or, where prescribed, abstain from alcohol, beer, taking illegal drugs, high risk mix of multiple substances and cigarettes. | |
| 14. Leisure Entertainment | Enjoy a variety of activities with others & alone; e.g., watch & play sports, TV, books, magazines, arts, crafts, movies, board games, music, dance, and radio. | |
| 15. Community Resources | Use community or public assistance services: self-help groups, religious organizations, shops/stores, MARTA bus/trains, library, job help lines. | |
| 16. Peers/Social | Get along with friends, neighbors, co-workers, peers of like age. | |
| 17. Sexual Behavior | Exhibit appropriate behavior towards others such as respects self and peers' sexual privacy; no sexually harassing, exploiting behaviors. | |
| 18. Productivity and work | Independently work or volunteer, complete homemaking, childcare responsibilities, participate in school, learn skills for financial self-support. | |
| 19. Coping Skills | Know diagnosis/symptoms of illness; use different options for coping, feel ok about self; regain self control reasonably well under stress. | |
| 20. Behavior Norms | Exhibit self-control over verbal or physical anger, abusive, threatening, anti-social, dangerous, violent, nuisance or bizarre behaviors. Law-abiding. | |

[2]Adapted from Daily Living Activities Scale, Will Pressmanes, with permission

What **problems** or **needs** do you have that might hinder your treatment or ability to reach your desired goals?

What **preferences** do you have regarding your treatment program at Southeast Kansas Mental Health Center?

## FAMILY OF ORIGIN

You were raised by? ☐ parents ☐ parent/step-parent ☐ single parent ☐ Other _____

List any developmental problems you recall experiencing such as premature birth, bedwetting, slow physical development, speech problems, delayed sexual development.

_____

What do you think about how you were raised?_____

_____

What kind of relationship do you have today with those who raised you? _____

How many brothers or sisters do you have? _____

What kind of relationship did do you have with your brothers and sisters?_____

_____

Did those who raised you, or your brothers/sisters have mental health or drug/alcohol problems? What about extended family?

_____

What problems did you have as a child or adolescent? (mental health, drug/alcohol, neglect, abuse, etc.)

_____

What significant issues about your childhood would you add to this information?

## SEXUAL HISTORY (Reminder: You may choose not to answer any of the following questions)

| | | |
|---|---|---|
| Did your family or school provide sex education? | ☐ yes | ☐ no |
| Have you engaged in sexual behavior? | ☐ yes | ☐ no |
| Were you prepared to enter into a sexual relationship? | ☐ yes | ☐ no |
| Have you ever been forced to have sexual contact? | ☐ yes | ☐ no When? _____ |
| Have you ever contracted a sexually transmitted disease? | ☐ yes | ☐ no |
| Have you participated in High-Risk behavior for HIV? | ☐ yes | ☐ no |

(multiple sexual partners, or a partner with multiple sexual partners, shared needles, homosexual behavior)

What other significant sexually oriented problems do you wish to discuss?

## EDUCATIONAL HISTORY

What is the last grade you completed? ☐ 6th or less ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED

College: ☐ freshman ☐ sophomore ☐ junior ☐ senior ☐ masters ☐ doctorate

Any specialized or technical training (i.e., cosmetology, welding, etc.)? _____

Are you currently pursuing your education? ☐ yes ☐ no What field of study? _____

What was your average grade during your last three years of schooling? ☐ A ☐ B ☐ C ☐ D ☐ F

What problems with learning did you have? _____

Did you have testing to assess for learning disabilities or ADHD problems? _____

Were you in resource or special education classrooms? _____

How well did you get along with teachers? _____

What other significant education related information do you want to add?

## MILITARY SERVICE

☐ Check here if never in the military Which branch did you serve in? _____ For ____ Years

Why did you leave? _____

What problems did you experience in the military? _____

What type of discharge did you receive? _____

What significant military related information do you want to add?

## EMPLOYMENT, FINANCES AND LEISURE

Are you currently: ☐ employed ☐ unemployed ☐ laid off ☐ on disability How long? _____

Where did you last work (or currently work)? _____

What was/is your position there? _____

Where did you work the longest? _____ How long? _____

How many jobs have you had in the last 5 years? _____

## SPIRITUAL BACKGROUND

With what religion do you identify?

☐ None ☐ Christianity ☐ Judaism ☐ Islam ☐ Buddhism ☐ Taoism ☐ Native American
☐ Other: _____

Are you a member of a local religious group? ☐ yes ☐ no Which one? _____
How active are you? ☐ extremely ☐ very ☐ somewhat ☐ not at all
How important is your faith? ☐ extremely ☐ very ☐ somewhat ☐ not at all

What problems have you had regarding spiritual issues? _____

How might your faith/spirituality help you overcome your problems? _____

Is there any spiritually related information you would like to add?

## LEGAL HISTORY (Reminder: You may choose not to answer any of the following questions)

Have you ever been arrested or taken to court? ☐ yes ☐ no
Have you ever been placed in a correctional institution? ☐ yes ☐ no When? _____ How Long? _____

Juvenile arrests? _____

Adult arrests? _____

What are your current legal issues or problems? _____

_____

## MEDICAL HISTORY

Have you had any of the following symptoms in the past 60 days?

| | | | | |
|---|---|---|---|---|
| ☐ Ankle Swelling | ☐ Coughing | ☐ Lightheadedness | ☐ Penile Discharge | ☐ Urination Difficulty |
| ☐ Breathing Difficulty | ☐ Pulse Irregularity | ☐ Memory Problems | ☐ Cramps | ☐ Bedwetting |
| ☐ Vomiting | ☐ Vision Changes | ☐ Seizures | ☐ Vaginal Discharge | ☐ Blood in Stool |
| ☐ Muscle Weakness | ☐ Shakiness | ☐ Dizziness | ☐ Nervousness | ☐ Diarrhea |
| ☐ Mole/Wart Changes | ☐ Tremor | ☐ Falling | ☐ Sleep Problems | ☐ Constipation |
| ☐ Hair Change | ☐ Nosebleeds | ☐ Confusion | ☐ Gait Unsteadiness | ☐ Sweats (Night) |
| ☐ Hearing Loss | ☐ Chest Pain | ☐ Panic Attacks | ☐ Numbness | ☐ Sweats (Other) |
| ☐ Headaches | ☐ Tingling in Arms & Legs | ☐ Loss of Consciousness | ☐ Rash | ☐ Bleeding gums |

Pregnant? ☐ yes ☐ no If yes, expected delivery date _____
Hospitalized in last three (3) years? ☐ yes ☐ no If yes, where and why _____

_____

Allergies/Drug Sensitivity: ☐ None ☐ Food _____

☐ Medication _____ ☐ Other _____

Weight Change in last year by more than five (5) pounds? ☐ yes ☐ no If yes, how much (+/-) _____

Any of the following:

| Problem | Now | Past | Never | Medical Treatment Date(s) |
|---|---|---|---|---|
| Anemia | | | | |
| Arthritis | | | | |
| Asthma | | | | |
| Bleeding Disorder | | | | |
| Blood Pressure (High or Low) | | | | |
| Bone/Joint problems | | | | |
| Cancer | | | | |
| Cirrhosis / Liver Disease | | | | |
| Diabetes | | | | |
| Epilepsy / Seizures | | | | |
| Eye Disease / Blindness | | | | |
| Fibromyalgia / Muscle Pain | | | | |
| Glaucoma | | | | |
| Headaches | | | | |
| Head Injury / Brain Tumor | | | | |
| Hearing Problems / Deafness | | | | |
| Heart Disease | | | | |
| Hepatitis / Jaundice | | | | |
| Kidney Disease | | | | |
| Lung Disease | | | | |
| Menstrual Pain | | | | |
| Oral Health/ Dental | | | | |
| Stomach / Bowel Problems | | | | |
| Stroke | | | | |
| Thyroid | | | | |
| Tuberculosis | | | | |
| AIDS/HIV | | | | |
| Sexual Transmitted Disease | | | | |
| Learning Problems | | | | |
| Speech Problems | | | | |
| Anxiety | | | | |
| Bipolar Disorder | | | | |
| Depression | | | | |
| Easting Disorder | | | | |
| Hyperactivity / ADD | | | | |
| Schizophrenia | | | | |
| Sexual Problem | | | | |
| Sleep Disorder | | | | |
| Suicide Attempts / Thoughts | | | | |

## ALCOHOL & DRUG USE AND TREATMENT (You may choose not to answer any of the following questions.)

| CATEGORY | AGE STARTED | AGE STOPPED OR CURRENT | AVERAGE FREQUENCY IN PAST YEAR | AVERAGE AMOUNT USED EACH TIME | COMMENTS |
|---|---|---|---|---|---|
| ALCOHOL (beer, wine, liquor) | | | | | |
| CAFFEINE (coffee, tea, soda, "No-Doze," etc.) | | | | | |
| NICOTINE (cigarettes, chew, snuff, cigars, pipe) | | | | | |
| STIMULANTS (cocaine, crack, crank, speed, amphetamines, methamphetamine, pseudoephedrine, ephedrine) | | | | | |
| CANNABIS (marijuana, hashish, hash oil) | | | | | |
| SEDATIVE HYPNOTICS (barbiturates, ie, Seconal, Phenobarbital; benzodiazepines, ie, Valium, Xanax, sleeping pills; Quaalude, Doriden) | | | | | |
| HALLUCINOGENS (LSD, PCP, mushrooms, ketamine, ecstacy, MDMA) | | | | | |
| INHALANTS (glue, paint, solvents, rush, gasoline, white out) | | | | | |
| OPIOIDS (opium, morphine, heroin, codeine, methadone) | | | | | |
| OTHER (dextromethorphan, steroids, etc) | | | | | |

What treatment have you had for Alcohol/Drug related problems? ☐ none ☐ AA/NA
☐ outpatient treatment ☐ residential treatment ☐ detoxification ☐ hospitalization

Where? _____

Other substance use related information you would like to add?

1) ☑ Check only **Problem Areas** with moderate or greater distress.
2) For each checked, also check the level of **Distress**, how long this has been a problem (**Duration**) and how often problem **Occurs**.

| | PROBLEM AREAS | DISTRESS | | | DURATION | | | | | OCCURS | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Moderate | Significant | Extreme | Less than 6 months | 6 | 12 | 24 | over 24 months | Constantly | Daily | Weekly | Monthly | Less often |
| ☐ | Anger Management / Temper | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Antisocial Behavior/Legal System | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Anxiety or Panic | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Attention/Concentration Problems | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Childhood Trauma or Abuse | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Chronic Pain/Physical Problems | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Couple Problems | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Dependency | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Depression | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Eating Disorder | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Family Conflict | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Functioning in Daily Living Skills | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Impulse Control | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Job Related Stress | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Losing Touch With Reality | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Low Self-Esteem | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Manic or "Hyper" | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Obsessive and/or Compulsive | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Paranoid or Suspicious | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Parenting Problems | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Phobias/Fears | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Posttraumatic Stress | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Sexual Abuse | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | *Sexual Confusion or Behavior* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Sexual Dysfunction | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Sleep Disturbance | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Social Discomfort | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Social Skills | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Spiritual Confusion | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Substance Abuse/Dependence | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Suicidal Thoughts/Attempts | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Thinking Problems | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Unresolved Grief/Loss | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Other: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | Other: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## MENTAL HEALTH HISTORY & TREATMENT

☐ Check here if you have never been in mental health treatment

### OUTPATIENT TREATMENT HISTORY

| Treated By: | From: Date to Date | | For What Problems? | Results of Treatment |
|---|---|---|---|---|
| | | | | |

### PSYCHIATRIC HOSPITALIZATIONS

| Hospital: | From: Date to Date | | For What Problems? | Results of Treatment |
|---|---|---|---|---|
| | | | | |

### PSYCHIATRIC MEDICATIONS

| Medication | Amount | Prescribed By: | Taken From Date to Date | | Results of Treatment |
|---|---|---|---|---|---|
| | | | | | |

What mental health related information would you like to add?

After completing treatment, how do you plan to maintain progress? _____

*Thank you for taking the time to complete this background information.*
*Please place this in the envelope provided, put your name on the outside and seal envelope to insure privacy.*
*Bring to your appointment.*