Southeast Kansas Mental Health Center

AshleyClinic

BACKGROUND INFORMATION

Please take the time to complete this information form before your appointment. Bring the complete form with you to your appointment. If you need additional space to give more detail for a section, please write on the back. This information is protected under Federal Regulations governing Confidentiality of Substance Use Client Records and the Health Insurance Portability and Accountability Act (HIPPA).

Name: _____ **Date:** _____
First Middle Last

Prescription Medication:

Are you currently taking any medication? ___No ___Yes

Medication: _____ Dose: _____ Frequency: _____

Why Prescribed: _____ When Prescribed: _____ Doctor: _____

Medication: _____ Dose: _____ Frequency: _____

Why Prescribed: _____ When Prescribed: _____ Doctor: _____

Medication: _____ Dose: _____ Frequency: _____

Why Prescribed: _____ When Prescribed: _____ Doctor: _____

Medication: _____ Dose: _____ Frequency: _____

Why Prescribed: _____ When Prescribed: _____ Doctor: _____

Employment History (5 years required)**:**

Employer: _____ Type of Work: _____

City: _____ From-To: _____

Employer: _____ Type of Work: _____

City: _____ From-To: _____

Employer: _____ Type of Work: _____

City: _____ From-To: _____

Employer: _____ Type of Work: _____

City: _____ From-To: _____

Employer: _____ Type of Work: _____

City: _____ From-To: _____

Legal History: List your lifetime arrest record.

Date: _________________ Offense: _______________________ Substance Related: ___Yes ___No

Location (City or County, State): __________________________ Jail Time: __No ___Yes/How long: _____

Date: _________________ Offense: _______________________ Substance Related: ___Yes ___No

Location (City or County, State): __________________________ Jail Time: __No ___Yes/How long: _____

Date: _________________ Offense: _______________________ Substance Related: ___Yes ___No

Location (City or County, State): __________________________ Jail Time: __No ___Yes/How long: _____

Date: _________________ Offense: _______________________ Substance Related: ___Yes ___No

Location (City or County, State): __________________________ Jail Time: __No ___Yes/How long: _____

Date: _________________ Offense: _______________________ Substance Related: ___Yes ___No

Location (City or County, State): __________________________ Jail Time: __No ___Yes/How long: _____

Date: _________________ Offense: _______________________ Substance Related: ___Yes ___No

Location (City or County, State): __________________________ Jail Time: __No ___Yes/How long: _____

Alcohol Drug Treatment History:

Have you ever been in a treatment center for substance use problems? ___No ___Yes

Date: ___________ Name of Treatment Center: _________________________ Number of Days: ____

City/State: ______________________ _____Inpatient or ____ Outpatient Completed: ___Yes ___No

Date: ___________ Name of Treatment Center: _________________________ Number of Days: ____

City/State: ______________________ _____Inpatient or ____ Outpatient Completed: ___Yes ___No

Date: ___________ Name of Treatment Center: _________________________ Number of Days: ____

City/State: ______________________ _____Inpatient or ____ Outpatient Completed: ___Yes ___No

Date: ___________ Name of Treatment Center: _________________________ Number of Days: ____

City/State: ______________________ _____Inpatient or ____ Outpatient Completed: ___Yes ___No

Date: ___________ Name of Treatment Center: _________________________ Number of Days: ____

City/State: ______________________ _____Inpatient or ____ Outpatient Completed: ___Yes ___No