RETURNING CLIENT
ADULT INFORMATION FORM

Name_____Date of Appt._____
Address_____City_____Zip_____
Telephone Numbers: H)_____W)_____Cell)_____
Is it okay if we leave brief messages at all three numbers? _____
If not, NO to which one? _____
Email Address: _____
Date of Birth_____Age_____Sex_____Married or Life Partner?_____
Years Married/Living Together_____Times Married_____

FAMILY MEDICAL & SOCIAL HISTORY:
Have you been hospitalized for anything since your last visit here, including psychiatric inpatient or Intensive Outpatient (IOP)? YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any medications you are currently taking:

Medicine	Dosage	Reason Prescribed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who are doctors prescribing the above medications: _____
_____
Who is your psychiatrist? _____
Who is your PCP & his/her number?_____
(Primary Care Physician)
May we contact your Psychiatrist and/or PCP to discuss care? YES NO
Please sign for either answer _____

Do you use recreational drugs: YES NO If no: have you used previously? YES NO
If yes, when did you stop? _____
If yes, please list:

Type of Drug	How Much	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you drink alcohol: YES NO If no:have you drank previously: YES NO
If yes: when did you stop? _____

If yes, please list:

Type of Alcohol	How Much	How Often
_____	_____	_____
_____	_____	_____

Describe any important medical history, chronic ailments and other health problems you experience: _____
_____
_____
_____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments: _____
_____
_____

Do you have any close relative (father, mother, brother, sister) who have experienced depression or other emotional problems? Please list: _____
_____
_____

SCHOOL & FAMILY HISTORY: Have you attended or graduated from a school or training program since you were here before? YES NO If yes, please list:

School/Program:_____Date Completed:_____

MOTHER	FATHER
_____living	_____living
_____deceased	_____deceased
_____married	_____married
_____divorced	_____ divorced
_____remarried _____#of times	_____remarried _____ (#of times)

Does the above information represent any changes in your parent's lives or status from before? YES NO If yes, please explain_____
_____

Where do your parents live: Mother_____
Father_____
MARITAL HISTORY: Current marital status: _____Single/never married _____Married_____Separated_____Divorced_____Widowed_____Living with someone. If currently married, when were you married?_____If living with someone, how long have you lived together?_____How many times have you been married?_____.

Please list your children:

Name	Age	Relationship(natural/step)	Lives with

Others living in the home with you:

NAME	RELATIONSHIP	AGE	GRADE/OCCUPATION

MENTAL STATUS: Please check any of the following that describe how you have been feeling or acting in the last two to six months or related to the reason you are here:
____sad/depressed____anxious _____panic ____angry ____irritable ____resentful ____worthless ____tearful ____jealous ____hopeless _____helpless ____loss of sexual interest _____guilty _____ashamed ____loss of interest in activities normally interesting or fun ____low energy ____extreme mood fluctuations (discrete periods of euphoria & high energy followed by periods of deep depression & isolation) ___aggressive ____thoughts of death ____loss of concentration ____phobia(s)
_____
___obsessive thinking re: _____
_____compulsions:_____
_____
_____ intrusive thoughts or images _____frightened _____hypervigilance
Describe any other feelings you have had or elaborate on any checked from above:
_____
_____
_____
_____
_____
Have you had any change in sleeping habits? YES NO Describe
_____
_____
Have you had any change in your appetite? YES NO
Decribe_____
Has there been weight loss___ or gain____? How much?_____In what time span?_____
Have you ever considered suicide in connection to your **current** problems? YES NO
If so, please give a brief description with dates:
_____
_____
_____

Have you ever **considered** suicide in the **past**? YES NO

Have you **attempted** suicide recently or in the past YES NO If so, please give a brief description with dates:_____

_____

Have you had any homicidal thoughts recently or concerning your current problem?
YES NO If yes, please explain_____

_____

LEVEL OF FUNCTIONING: List or describe any current impediments or problems in daily behavioral, psychological, social or occupational functioning, i.e. isolation from friends/family, significant difficulty getting to work or making self do daily tasks, poor concentration or impaired memory, severe financial strain, recent divorce or problems with supervisor, etc.

_____
_____
_____
_____
_____
_____

THOUGHTS: Please check any of the following that apply to you.

_____I sometimes hear voices even though no one nearby is talking to me
_____I sometimes feel that forces outside of me control me
_____I sometimes feel that other people control my thoughts
_____I sometimes have the same thought over and over and cannot control it.
_____I sometimes feel that someone is out to hurt me or do something against me.
_____I am sometimes unable to control my behavior; Please explain_____

_____

Is there any other information regarding you or your family you would like to share with your therapist that is not covered on this form, or use this space to complete earlier responses.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I hereby consent to treatment by the specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have the right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X_____Date_____

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

X_____ Date_____

I authorize the payment of medical benefits to the provider of services.

X_____Date_____

PLEASE READ THE FOLLOWING CAREFULLY:

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. Heritage Behavioral Health will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

I realize that I will be charged $75.00 for appointments not cancelled within 24 hours of the appointment time.

Signature_____Date_____