

**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:

| <u>Type of Alcohol</u> | <u>How Much</u> | <u>How Often</u> |
|------------------------|-----------------|------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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 _____ living | FATHER _____ 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:

| <u>Name</u> | <u>Age</u> | <u>Relationship(natural/step)</u> | <u>Lives with</u> |
|-------------|------------|-----------------------------------|-------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

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, nightmares 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

Describe _____

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 \$90.00 for appointments not canceled within 24 hours of the appointment time.

Signature _____ Date _____