Form 2D-a

NORTHERN PINES MENTAL HEALTH CENTER

CLIENT INFORMATION—ADULT FORM
PRIVATE AND CONFIDENTIAL

TODAY'S DATE

CLIENT				
LAST NAME	FIRST NAME			MIDDLE INITIAL
MAIDEN NAME	DATE OF BIRTH	AGE	GENDER	SOCIAL SECURITY
HOME ADDRESS				
CITY	ZIP CODE			COUNTY
HOME PHONE ☐Preferred	WORK PHONE ☐Preferred			CELL PHONE ☐Preferred
Race/Ethnicity: ☐ Black ☐White ☐Hispanic ☐Asian/Pacific Islander ☐American Indian/Alaskan Native ☐Other				
Primary Language				
CURRENT RELATIONSHIP STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other	SPOUSE NAME			DATE OF BIRTH

EMERGENCY INFORMATION			
The name of the person to contact in the event of a medical emergency			
NAME	**RELATIONSHIP**	**PHONE**	**ADDRESS**
In the event of a medical emergency, I authorize Northern Pines Mental Health Center to contact the above person **Signature** **Date**			

CURRENT MENTAL HEALTH CONCERNS
The concern which led me to make an appointment here is:

TREATMENT GOALS
What do you hope to change by coming here?

EDUCATIONAL STATUS
List the highest grade completed. Have you ever received Special Educational services ☐ Yes ☐ No

CURRENT HOUSEHOLD INFORMATION (persons currently living in the household)

	Name	Relationship to me	Age	Gender	Place of Employment or School and grade
1					
2					
3					
4					
5					
6					

Are there family members who are living apart from me at this time? ☐ Yes ☐ No
I expect changes in my household within the coming year. ☐ Yes ☐ No

LIFE EXPERIENCES THAT HAVE HAPPENED TO…		
Me	Someone close to me	
☐ Yes ☐ No	☐ Yes ☐ No	Alcohol or drug use
☐ Yes ☐ No	☐ Yes ☐ No	Physical abuse or battering
☐ Yes ☐ No	☐ Yes ☐ No	Sexual abuse, molestation, or rape
☐ Yes ☐ No	☐ Yes ☐ No	Neglect
☐ Yes ☐ No	☐ Yes ☐ No	Physical disability
☐ Yes ☐ No	☐ Yes ☐ No	Chronic illness
☐ Yes ☐ No	☐ Yes ☐ No	Mental illness
☐ Yes ☐ No	☐ Yes ☐ No	Special Education services
☐ Yes ☐ No	☐ Yes ☐ No	Suicide or Suicide attempts
☐ Yes ☐ No	☐ Yes ☐ No	Religious affiliation
☐ Yes ☐ No	☐ Yes ☐ No	War experience as a civilian or military person
☐ Yes ☐ No	☐ Yes ☐ No	Loss of a loved one through death
☐ Yes ☐ No	☐ Yes ☐ No	Frequent moving or relocation
☐ Yes ☐ No	☐ Yes ☐ No	Natural disaster (flood, earthquake, tornado)
☐ Yes ☐ No	☐ Yes ☐ No	Abduction or kidnapping
☐ Yes ☐ No	☐ Yes ☐ No	Family separation or divorce
☐ Yes ☐ No	☐ Yes ☐ No	Other significant event (specify)

MEDICAL INFORMATION

Name of Physician/Medical Clinic: _____

Name of Pharmacy: _____

☐*Medication List Attached* Name of Medication		Reason	Amount	Last dose taken was: (when)	Frequency	Date 1st started this medication	Take medication as prescribed?
1							☐ Yes ☐ No
2							☐ Yes ☐ No
3							☐ Yes ☐ No
4							☐ Yes ☐ No
5							☐ Yes ☐ No

☐ Yes ☐ No Any adverse reaction to the listed medications? _____

☐ Yes ☐ No Allergies: _____

Current Medical issues:

Specialist seen:

Previous surgeries:

PAST MEDICAL HISTORY		Please Explain
☐ Yes ☐ No	Head Injuries	
☐ Yes ☐ No	Seizures	
☐ Yes ☐ No	Serious Illnesses	
☐ Yes ☐ No	Serious Injuries	
	Other Medical Issues	
HEALTH CARE DIRECTIVE		
☐ Yes ☐ No	Do you have a Health Care Directive, if not we encourage you to check with your Primary physician for information on completing one if interested.	

MENTAL HEALTH HISTORY

	Name of Counselor/ Therapist/ Doctor:	Name of the Clinic/ Hospital:	Address/City/State	The Date(s) I went there were:
1				
2				
3				
4				
5				

The following mental health problems were/are in my family of birth (parents, brothers, sisters, and others relatives)

☐Depression ☐Suicide
☐Bipolar disorder (manic –depression) ☐Alcohol abuse/dependence
☐Schizophrenia ☐ADHD/ADD (hyperactivity)
☐Panic attacks ☐Other:

SELF-HARM CONCERNS

☐ Yes ☐ No I have **recently experienced** a desire or urge to kill **myself**.
☐ Yes ☐ No I have **attempted** to kill **myself** in the past.
☐ Yes ☐ No I am **currently experiencing** thoughts or urges to injure or harm myself.
☐ Yes ☐ No I have **engaged** in self-injuries or harmful behaviors.

VIOLENCE CONCERNS

☐ Yes ☐ No I have recently experienced a desire or urge to seriously harm or kill someone else.
☐ Yes ☐ No I have attempted to harm/hurt other people in the past (hitting, shoving, choking, punching, kicking, etc.)
☐ Yes ☐ No I have a history of violent or destructive behavior.

ADDITIONAL SERVICES RECEIVED

	I have received help from Social Services	**Name of worker**	**Reason**
☐ Yes ☐ No	Financial Assistance		
☐ Yes ☐ No	Child Welfare Issues		
☐ Yes ☐ No	Case Management		
☐ Yes ☐ No	Other Social Services		

	I have received help from	**Name of worker**	**Reason**
☐ Yes ☐ No	I attend Our Place or receive Outreach Services		
☐ Yes ☐ No	In-Home Family services		
☐ Yes ☐ No	Probation/Parole services		
☐ Yes ☐ No	Currently involved in pending law suits or other Court-related actions		
☐ Yes ☐ No	I anticipate that my treatment records will be used in court		

CHEMICAL USE INFORMATION

Current or recent use		Date of last use	# of times this week you used	Date first began to use this drug	Do you think you have a problem with this drug?
☐ Yes ☐ No	Marijuana/pot				☐ Yes ☐ No
☐ Yes ☐ No	Cocaine				☐ Yes ☐ No
☐ Yes ☐ No	Crack				☐ Yes ☐ No
☐ Yes ☐ No	Heroin				☐ Yes ☐ No
Current or recent use		Date of last use	# of times this week you used	Date first began to use this drug	Do you think you have a problem with this drug?
☐ Yes ☐ No	LSD				☐ Yes ☐ No
☐ Yes ☐ No	Designer Drugs				☐ Yes ☐ No
☐ Yes ☐ No	Amphetamines				☐ Yes ☐ No

Current or recent use		Date of last use	# of times this week you used	Date first began to use this drug	Do you think you have a problem with this drug?
☐ Yes ☐ No	Barbiturates				☐ Yes ☐ No
☐ Yes ☐ No	Inhalants				☐ Yes ☐ No
☐ Yes ☐ No	Other:				☐ Yes ☐ No
ALCOHOL USE					
☐ Yes ☐ No	Beer				☐ Yes ☐ No
☐ Yes ☐ No	Wine				☐ Yes ☐ No
☐ Yes ☐ No	Liquor				☐ Yes ☐ No

NICOTINE USE			
		How often do you use this product	Would you like help in reducing or stopping the use?
☐ Yes ☐ No	Cigarettes		☐ Yes ☐ No
☐ Yes ☐ No	Chewing tobacco		☐ Yes ☐ No
☐ Yes ☐ No	Other (pipe,cigars,etc.)		☐ Yes ☐ No
☐ Yes ☐ No	Vapor		☐ Yes ☐ No

CAGE-AID

1. ☐ Yes ☐ No Have you ever felt you ought to cut down on your drinking or drug use?
2. ☐ Yes ☐ No Have people annoyed you by criticizing your drinking or drug use?
3. ☐ Yes ☐ No Have you felt bad or guilty about your drinking or drug use?
4. ☐ Yes ☐ No Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?

How many times have you participated in some type of gambling within the past month?
☐ Never ☐ Once ☐ 2-4 times ☐ 5-10 times ☐ More than 10 times
Has your gambling created financial problem for your family?
☐ No ☐ Yes, in the past but not currently ☐ Yes, it is currently creating problems

Signature of Client	Date