Mercy

Mercy Clinic Behavioral Health
Adult Information Form

Today's Date: _____

Patient's Name: _____ SSN: _____

Who is legally responsible for this patient?_____ Phone: _____

Name of the person completing this form: _____ Relationship to Patient: _____

How did you hear about us? ❑ Phone Book ❑ Advertisement ❑ Family ❑ Friend
❑ Physician ❑ Insurance ❑ Employer ❑ Other:_____

What religious preference do you have?_____

❑ Yes ❑ No Do you have any specific cultural or spiritual needs or beliefs that should be addressed?
If "Yes," please describe:_____

Who is your primary physician? _____ Located at: _____

Name of any specialist: _____ Located at: _____

❑ Yes ❑ No Do you have Advance Health Care Directives (Durable Power of Attorney, Living Will)?

Military Service Branch: _____ Years of Service: _____
Type of Discharge: _____ Retired: ❑ Yes ❑ No

Years of school completed: _____
❑ HS Grad ❑ GED College: ❑ Some ❑ Graduated ❑ Grad School

What is your occupation? _____ What department do you work in? _____

What is the location or your employer/school? _____ How long with this employer? _____

What shift do you work? ❑ Days ❑ Evenings ❑ Nights ❑ Split

How long at your current address? _____ Do you plan to live there the next 6 months? ❑ Yes ❑ No

Are you? ❑ Single ❑ Single Parent ❑ Divorced ❑ Separated ❑ Living with Parents ❑ Married
❑ Living with Significant Other ❑ Widowed ❑ Blended family ❑ Living with Children
❑ Other Status: _____ How many years in current status? _____

Number of previous marriages? _____ Please provide the dates: _____

Who should be contacted in case of emergency? _____

Relationship: _____ Phone: Home: _____ Work: _____

CHIEF CONCERN

Please describe what prompted you to contact us.

_____

_____

_____

_____

How long have these issues existed? _____

What do you hope will happen from treatment? _____

Stressors: Please check all that apply.

❑ Past physical, emotional, or sexual abuse
❑ Homelessness/Moved
❑ Traumatic event
❑ Legal problems/proceedings
❑ Witness to violence
❑ Other: _____
❑ Separated/Divorced? When? _____
❑ Loss of a family member, friend, or pet
❑ Work or school problems
❑ Financial problems
❑ Physical problems
❑ Memory problems

Activities:

How is your leisure time spent? ❑ Alone ❑ With Family ❑ With Others

What indoor and/or outdoor leisure activities do you do, and how often?

_____

_____

_____

Feelings and Habits:

In times of difficulty or illness, does you find your spirituality to be: ❑ Source of comfort ❑ Source of strength
❑ Seldom helpful ❑ Of no help ❑ Source of stress

❑ Yes ❑ No Do you have difficulty expressing opinions or feelings? If "Yes," explain

_____

_____

What do you do when you get angry?

_____

_____

Please list 3 words that describe yourself: _____

Generally, how do you feel about yourself? ❑ Very Good ❑ Good ❑ Neutral ❑ Bad ❑ Very Bad

Please describe your relationship with your:

Friends:_____

Family: _____

Coworkers: _____

❑ Yes ❑ No Do you drink alcohol? If "Yes," please indicate: ❑ Daily ❑ A couple of days per week
❑ Less than once per week How many ounces per day? _____

❑ Yes ❑ No Do you use street drugs? Date last used: _____ Kind: _____

❑ Yes ❑ No Do you smoke? (Packs per day_____) Drink caffeinated beverages? (Cups/can per day _____)

❑ Yes ❑ No Legal, family, or work problems related to alcohol or drugs?

❑ Yes ❑ No Have you had a recent weight ❑ Loss ❑ Gain If "Yes," how much? _____

❑ Yes ❑ No Appetite changes with stress?

❑ Yes ❑ No Do you use vitamins, herbs, or food supplements? If "Yes," please indicate the kinds and amounts:

_____

_____

Times per week you eat: ❑ Breakfast ❑ Lunch ❑ Dinner ❑ Restaurants/fast food

Describe your eating habits: _____

Family Information - Please list all people living in the household.

Name	Age	Relationship	Place of Work	Problems in relationship? Yes	Neutral	No
_____	_____	_____	_____	❑	❑	❑
_____	_____	_____	_____	❑	❑	❑
_____	_____	_____	_____	❑	❑	❑
_____	_____	_____	_____	❑	❑	❑
_____	_____	_____	_____	❑	❑	❑
_____	_____	_____	_____	❑	❑	❑

Family History: Have any relatives had any of the problems listed below? If so, indicate, "parent, grandparent, aunt, uncle, brother, sister, or cousin" in the section under "Relationship."

Problem	Yes	No	Relationship
Depression/suicide attempted/completed suicide	❑	❑	_____
Schizophrenia	❑	❑	_____
Strange thoughts/behavior	❑	❑	_____
Paranoid thinking	❑	❑	_____
Extreme mood swings - Manic Depression	❑	❑	_____
Nervousness/anxiety/panic	❑	❑	_____
Nervous Breakdown	❑	❑	_____
Worry/fearfulness	❑	❑	_____
Substance abuse (drugs/alcohol)	❑	❑	_____
Attention Deficit/Hyperactivity Disorder	❑	❑	_____
Obsessive Compulsive Disorder	❑	❑	_____
Tics/Seizures	❑	❑	_____
Physical, sexual, or other abuse	❑	❑	_____
Alzheimer's or other dementias	❑	❑	_____

❑ Yes ❑ No Have you or are you being treated for one of the problems listed above? If "Yes," please explain.

_____

_____

Who did you see for the problem(s)? _____

❑ Yes ❑ No Have you been hospitalized for mental health problems? If "Yes," when? _____

Medical History

❑ Yes ❑ No Are you currently receiving treatment for any medical problems?

❑ Yes ❑ No Allergic to medication? If "Yes," name the medication and describe the problem it causes.

_____

_____

❑ Yes ❑ No Allergic to substances? If "Yes," name the substance and describe the problem it causes.

_____

_____

❑ Yes ❑ No Have you had the Hepatitis B vaccine?

❑ Yes ❑ No Have you had the Pneumonia vaccine?

❑ Yes ❑ No Do you have any physical limitation? Please describe.

_____

_____

Please check if you currently have or have ever had any of the following:

❑ Heart disease	❑ Diabetes	❑ Headaches	❑ Glaucoma	❑ Neurological problems
❑ GI problems	❑ Seizures	❑ Soiling	❑ Head injury	❑ Bladder/Kidney problems
❑ Thyroid problem	❑ Tics	❑ Dizziness	❑ Bed wetting	❑ Respiratory problems

For Females:

❑ Yes ❑ No Is there a possibility of pregnancy?

❑ Yes ❑ No Do you use birth control pills or a contraceptive device?

❑ Yes ❑ No In the process of or completed menopause?

For Males:

❑ Yes ❑ No Do you take hormone supplements?

What medications have you taken in the last 12 months, **but are not now taking?**

Medication	**How much**	**How often**	**Did it help**	**Reason stopped**

What medications, **prescribed** or **over-the-counter**, are you **currently** taking?

Medication	**How much**	**How often**	**Did it help**	**Date/time last dose**

Regarding prescription and over-the-counter medication, have you:

❑ Yes ❑ No Always followed directions?
❑ Yes ❑ No Quit them because you couldn't afford them?
❑ Yes ❑ No Take them only when you felt like it?
❑ Yes ❑ No Often take more than prescribed or recommended?
❑ Yes ❑ No Had to go to more than one physician to get what you needed?

❑ Yes ❑ No Is there other information that you think we should know to help you?

_____

_____

What additional follow-up and/or supportive relationships are available to you?

_____

_____

Please mark any areas you would like to learn more about:

❑ Community Resources ❑ Self-confidence ❑ Leisure Skills ❑ Assisted Living
❑ Substance Abuse ❑ Stress Management ❑ Current Diagnosis ❑ Anger Management
❑ Money Management ❑ Time Management ❑ Relationships ❑ Alternative Medicine
❑ Spiritual Resources ❑ Advance Directives ❑ Medications ❑ Communication
❑ Sexually Transmitted Disease ❑ Nutrition ❑ Grief and Loss ❑ Parenting Skills
❑ Other: _____ ❑ Other: _____

For Office Use Only. Further Assessment required by:

Social Services	_____ Initial	_____ Date Referred	Psychiatry	_____ Initial	_____ Date Referred
Nutrition	_____ Initial	_____ Date Referred	Medical	_____ Initial	_____ Date Referred
Pastoral	_____ Initial	_____ Date Referred	Psychology	_____ Initial	_____ Date Referred
Chemical Dep.	_____ Initial	_____ Date Referred	Other	_____ Initial	_____ Date Referred

Reviewer/Screener: _____ Time: _____ Date: _____