Prairie View Behavioral Health Services-Patient Information/Evaluation

(met12/01)

PATIENT NAME-Adult/Older Adult Services _____ ***Name of person filling out form*** _____ ***Relationship to patient*** _____

CONFIDENTIALITY: All patient information and records will be kept confidential in accordance with all pertinent state and federal laws as well as within the guidelines of professional codes of ethics. Two circumstances under which confidentiality are limited are outlined as follows: 1-In an instance where child or elder abuse is disclosed or suspected, the ·clinician is required by federal mandates to report this information to the local human service agency responsible for protecting these vulnerable populations. 2-In the event that information is disclosed that indicates to the clinician that a client or another party is at imminent risk of harm, there is a duty to warn the threatened party and to take the appropriate legal action as defined by state and federal statutes to protect the threatened party.

I have read/or had read to me the above information and understand the limits of confidentiality-

Patient Signature_____ Date_____

Legal Guardian (if other than patient)_____ Date_____

Does the patient have any of the following? *Advance Directives* *Conservator/Guardian* *Durable Power of Attorney*

Name _____ Phone ( ) _____*If yes, please provide copy of any documentation*

MEDICAL HISTORY/PERSONAL HABITS Patient Age_____ Gender _____

1) What problem brings you to seek treatment at this time?_____

2) Has this (problem) ever happened before? _____

If so, what treatments(s) have been helpful?_____

3) Are you currently in outpatient treatment? ☐Yes / ☐No Therapist_____ Phone ( ) _____

Why? _____ How long have you been seeing this therapist? _____

How often? ☐ WEEKLY / ☐ BI-WEEKLY / ☐ MONTHLY Last appointment _____

STAFF USE**********Current Medications (Prescription and Non-Prescription)**********STAFF USE

Medication	Dosage	Physician	Start Date	For:

Have you been consistently taking all medications as prescribed? ☐Yes / ☐No (describe_____)

4) Please describe any current health concerns / medical illness / pain_____

_____

5) When was your last complete physical? _____ Did it include lab / bloodwork? _____

PATIENT MEDICAL / PSYCHIATRIC HISTORY - Please circle all that apply Hearing loss Vision Loss *[glasses, contacts]*

Seasonal Allergies Diabetes Tuberculosis Heart Disease High Blood Pressure Thyroid problems Depression Anxiety

Schizophrenia Alcohol / drugs Violence Toward Others Suicide Attempts Psychiatric Hospitalizations Head Injury

Loss of Consciousness Seizure Disorder Cancer(type) _____ Surgeries: (type/date) _____

Abuse History ☐Yes / ☐No Describe any other major illness/injury _____

Medication allergies (describe reaction) _____Food allergies _____

Past Psychiatric Meds	From - To	For	Effect	Prescribing MD

Patient Last Name _____ Case Number _____

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6) Have you noticed any changes in your sleep / appetite that concern you? ☐Yes / ☐No

How many hours per night do you sleep? _____ Describe your sleep: ☐RESTFUL / ☐DISTURBED

Appetite – ☐SAME / ☐INCREASED / ☐DECREASED Weight gain / loss? ____Over what period of time _____

7) Are you currently sexually active? ☐Yes / ☐No

Are there any problems / concerns regarding sexual satisfaction? _____

8) Do you use tobacco? ☐Yes / ☐No How much do you use daily? _____

9) Have you ever used any street drugs? ☐Yes / ☐No If yes, what drugs?_____

10) Have you ever taken prescription medication in a way other than how the doctor prescribed it?☐Yes / ☐No

11) How many caffeinated beverages do you drink per day? ☐ 0-2 / ☐ 3-5 / ☐ 6 or more

12) Do you exercise? ☐Yes / ☐No How?_____ How often_____

13) Leisure / Recreation / Community Activities _____

14) Spiritual Affiliation_____ Contact Person_____ Phone. ( ) _____

a. Would you like this person to be notified of and involved in your treatment at Prairie View? ☐Yes / ☐No

b. On a scale of 1-10 (1-not important, 10-very important) how important is your faith to you? _____

FAMILY

FATHER _____ Age___ Town, ST_____ Health Status_____

MOTHER_____ Age___ Town, ST_____ Health Status_____

SIBLINGS (age/location) _____

If you were not raised by your biologic parents, with whom did you live? _____

FAMILY MEDICAL HISTORY - Please mark each that apply: "M" for mother's side, 'F" for father's side or "N" for none

Diabetes_____ Stroke_____ Heart Disease_____ High Blood Pressure_____ Dementia_____ Depression_____

Cancer/Type_____/_____ Anxiety_____ Schizophrenia _____ Suicide Attempts_____ Alcohol/Drugs_____ Abuse History_____

Antisocial Behavior (difficulties w/ police/violence) _____ Psychiatric Hospitalizations _____

EDUCATIONAL HISTORY - Highest Grade Completed_____ College / Vo-Tech_____ Degree_____

WORK HISTORY- What jobs have you held and for how long? _____

_____

Have you ever served in the military? ☐Yes / ☐No Dates of service_____ Branch_____

Rank at discharge_____ Eligible for Veteran's Benefits? _____

MARITAL HISTORY - Circle current - NEVER MARRIED MARRIED CO-HABIT DIVORCED WIDOWED

1st marriage to_____ years_____ status_____

CHILDREN: Name _____ age_____ location_____

Name _____ age_____ location_____

2nd marriage to_____ years_____ status_____

CHILDREN: Name _____ age_____ location_____

Name _____ age_____ location_____

Please list any other supportive persons in your life: NAME/RELATIONSHIP _____

STAFF USE: (Signature required only if not completing pgs. 4-7) *Patient information form reviewed as part of assessment process:*

Clinician Signature. _____ Date _____

Patient Last Name _____ Case Number _____