Prairie View
Behavioral & Mental Healthcare

Name:_____

Prairie View Case Number:_____

Adult
PATIENT INFORMATION FORM

This Patient Information Form is reviewed as part of the assessment process.

Name of person filling out form:	Relationship to patient:	Date:

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PATIENT DATA

Last Name:	First Name:	Middle Name:
Preferred Name:	Date of Birth:	Age:
Race:	Gender: ☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Other:_____	
Address: Street Address:		County:
City:	State:	ZIP Code:
Primary Phone: ( ) ☐ Home; ☐ Cell; ☐ Work	Secondary Phone: ( ) ☐ Home; ☐ Cell; ☐ Work	
Has patient been seen previously at Prairie View? ☐ Yes ☐ No		
Referral Source: ☐ Self ☐ Family ☐ Doctor ☐ Court ☐ DCF ☐ Other:_____		

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 in which confidentiality is limited are outlined as follows:

1) In an instance where child or elder abuse is disclosed or suspected, the clinician is required by state law 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 patient or another party is at imminent risk of harm, there is a duty to take appropriate action to protect the threatened party.

Also refer to NOTICE OF PRIVACY PRACTICES.

List all persons who are authorized to receive information regarding your care:

Name:	Relationship:
Name:	Relationship:

Does the patient have any of the following? If yes, please provide **copy of any documentation**.

Legal Guardian? ☐ Yes ☐ No **Advance Directives**? ☐ Yes ☐ No
Conservator? ☐ Yes ☐ No **Durable Power of Attorney**? ☐ Yes ☐ No

If yes, name of **Legal Guardian**:_____	Phone: ( )
If yes, name of **Conservator**:_____	Phone: ( )
If yes, name of **Durable Power of Attorney**:_____	Phone: ( )

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PRESENTING PROBLEM

Why are you seeking treatment at this time?_____

_____

Has this happened before? ☐ Yes ☐ No If yes, when?_____

What treatments have been helpful?

_____

How long has this been occurring?_____

List any major changes in your life within the last year:_____

_____

_____

List any current or previous mental health diagnoses:_____

_____

_____

Current Services – List any current mental health providers (therapy & medication) outside of Prairie View:

Name / Agency	Reason	How Often	How Long	Date of Last Appt.

Previous Services – List any previous mental health services, including reason and dates:

_____

_____

_____

_____

_____

CURRENT FUNCTIONING

(Check ALL that apply)

Current Concerns:

- ☐ Anger/Violence
- ☐ Anxiety/Worry
- ☐ Appetite/Eating
- ☐ Attention problems
- ☐ Hallucinations/Delusions
- ☐ Homicidal thoughts
- ☐ Impulse control
- ☐ Learning / School
- ☐ Mood/Depression
- ☐ Panic attacks
- ☐ Self-harm
- ☐ Sexual behaviors
- ☐ Sexuality
- ☐ Sleep
- ☐ Substance use
- ☐ Suicidal thoughts
- ☐ Trauma/Abuse

Sleep: How many hours per night do you sleep? _____ hours

☐ Restful ☐ Disturbed ☐ Nightmares ☐ Difficulty falling / staying asleep

Appetite: ☐ Increased ☐ Decreased ☐ Excessive ☐ Good ☐ Poor

Substance Use:

Do you drink **caffeinated beverages**? ☐ Yes ☐ No If Yes, how many drinks per day?_____

Do you use **tobacco/nicotine** products (examples: cigarettes, chewing tobacco, vaping, e-cigarette)? ☐ Yes ☐ No
If yes, how often? ☐ Frequently throughout the day ☐ Few times a day ☐ Daily ☐ Less than daily

Do you drink **alcohol**? ☐ Yes ☐ No If yes, how many drinks per day/week?_____

Do you use **illegal drugs** (including marijuana)? ☐ Yes ☐ No If yes, what drugs and how often?

_____
_____
_____

Leisure/Recreation:

Do you **exercise**? ☐ Yes ☐ No Type:_____ How Often?_____

What **leisure activities or hobbies** do you enjoy?_____

_____
_____

PSYCHOSOCIAL HISTORY

Family History:

Mother:_____

Health Status: ☐ Healthy ☐ Declining ☐ Seriously Ill ☐ Deceased
Relationship: ☐ Good/Positive ☐ Strained/Negative ☐ No Relationship
Lives In (city/state):_____

Father:_____

Health Status: ☐ Healthy ☐ Declining ☐ Seriously Ill ☐ Deceased
Relationship: ☐ Good/Positive ☐ Strained/Negative ☐ No Relationship
Lives In (city/state):_____

If you were not raised by your biological parents, by whom were you raised?

_____

List any siblings (include ages, relationship, where they live):

_____
_____
_____
_____

Relationship Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Committed Relationship

List any relationship concerns:_____

_____
_____

Are you sexually active: ☐ Yes ☐ No

Children: ☐ Yes ☐ No If yes, list ages & where they live:

_____
_____
_____
_____

List current Household Members:

_____
_____
_____

List sources of social support (examples: friends, relatives)**:**

_____

_____

_____

Current or Past Trauma / Abuse: ☐ Yes ☐ No If yes, check those that apply.

☐ Emotional ☐ Human Trafficking ☐ Perpetrator of Abuse ☐ Racial ☐ Verbal
☐ Exploitation ☐ Neglect ☐ Physical ☐ Sexual ☐ Witness to Abuse
☐ Other:_____

If yes to current or past trauma abuse, was it reported? ☐ Yes ☐ No
To whom?_____ Date(s):_____

Religious/Spiritual Preference:_____

How important is your faith to you?
☐ Not Important ☐ Somewhat Important ☐ Important ☐ Very Important

EDUCATION, EMPLOYMENT, AND LEGAL HISTORY

Education:

Highest grade completed:_____

Education After High School:
☐ Attended college/trade school, but did not complete
☐ Currently enrolled in college/trade school
☐ Graduated/completed college/trade school List degree earned:_____

Employment:

Are you **currently employed?** ☐ Yes ☐ No If yes, where?_____

List **employment history** for last 5 years:

	Place	How long?	Place	How Long?

Are you currently receiving **disability benefits**? ☐ Yes ☐ No

Have you ever served in the **military**? ☐ Yes ☐ No If yes, complete the following:

	Date Began	Date Ended	Military Branch	Type of Discharge

Legal:

Have you ever been arrested or convicted of a crime? ☐ Yes ☐ No If yes, complete below:

	Arrest Date	Type of Arrest

Are you currently on any of the following? ☐ Yes ☐ No If yes, choose below:
☐ Probation ☐ Parole ☐ Community Corrections ☐ Diversion

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MEDICAL HISTORY

ALLERGIES (list all medication and food allergies and describe reaction):

Name:_____ Reaction:_____
Name:_____ Reaction:_____
Name:_____ Reaction:_____
Name:_____ Reaction:_____

Do you have a **Primary Care Physician**? ☐ Yes ☐ No
If yes, name of provider:_____

Do you have any **ongoing pain** problems? ☐ Yes ☐ No
If yes, location of pain:_____
Rate 0-10 (0=none and 10=highest) Current Pain Level:_____ Typical Pain Level:_____

Describe any current **health concerns / medical illness / pain**:_____

Current **Height**:_____ Current **Weight**:_____

When was your last **complete physical**?_____
Did it include lab / blood work? ☐ Yes ☐ No
Comments:_____

Patient and Family History

Mark each that apply: "**P**" for patient, "**M**" for mother's side, "**F**" for father's side, "**S**" for sibling, "**C**" for child:

_____ ADHD	_____ Diabetes	_____ Psychiatric hospitalizations
_____ Alcohol / Substance abuse	_____ Hallucinations / Delusions	_____ PTSD
_____ Alzheimer's / Dementia	_____ Heart disease	_____ Schizophrenia
_____ Anxiety / Panic	_____ High blood pressure	_____ Stroke
_____ Cancer	_____ Mood swings / Bipolar	_____ Suicide attempts
_____ Depression	_____ Parkinson's disease	

Patient History (Check all that apply to patient only)

☐ Asthma	☐ Hearing loss	☐ Mumps	☐ Tonsillitis
☐ Chicken pox	☐ Kidney disease	☐ Rheumatic fever	☐ Tuberculosis
☐ COVID-19	☐ Liver disease	☐ Seasonal allergies	☐ Vision loss (glasses, contacts)
☐ Ear infections	☐ Loss of consciousness	☐ Seizure disorder	☐ Whooping cough
☐ Head injury	☐ Measles	☐ Thyroid problems	☐ Other:_____

List any past **hospitalizations / surgeries**, and approximate dates (including psychiatric hospitalizations):

_____ Dates:_____
_____ Dates:_____
_____ Dates:_____

Have you been to the **Emergency Room** in the last year? ☐ Yes ☐ No
If yes, cause of visit:_____

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MEDICATIONS

☐ I am NOT currently taking any prescription, over-the-counter medications, or supplements.

☐ I am taking the following prescription, over-the-counter medications, and supplements.

List ALL current prescription, over-the-counter medications, and/or supplements:

If patient lives in an agency setting or care facility,
please bring the current Medication Administration Record (MAR).

Name	Dosage	Frequency	Prescriber	Start Date	Reason