SANFORD HEALTH

Client#__________

Adult Service Application

Client Name: ______________________________________ Date: ____________________

Are you your own legal guardian? ☐ Yes ☐ No If no, who is your legal guardian? ____________

Former name/maiden name: ____

Sex: ☐ Male ☐ Female Sexual Orientation: ______________________________

SSN: __________________ Date of Birth: ____________ Age: ________

Address: ___________________________ City: ____________ State: _______ Zip: ____________

County of residence: ____

Home Phone: _________________ Work Phone: _________________ Cell Phone: ____________

OK to call? ☐ Yes ☐ No OK to call? ☐ Yes ☐ No OK to call? ☐ Yes ☐ No

Employment: ☐ Full-time ☐ Part-time ☐ Student ☐ Retired ☐ Unemployed

Employer: ______________________________ Occupation: ____________________________

Name of person completing form (if different from above): ______________________________

Race/Ethnicity *(check all that apply)*:

☐ Asian ☐ Black/African American ☐ Latino/Hispanic ☐ Native American/Native Alaskan

☐ White ☐ Native Hawaiian/Pacific Islander ☐ Bi/multi-racial ☐ Other

Enrolled in reservation? ☐ Yes ☐ No If yes, where? ______________________________

Are you a Veteran? ☐ Yes ☐ No

Is the reason you are wishing to be seen at SANFORD HEALTH BEHAVIORAL HEALTH military related?

☐ Yes ☐ No

Emergency contact name: ______________________________ Phone: ____________________

Relationship to emergency contact person: ______________________________________

Do you have a Mental Health Care Directive (living will)? ☐ Yes ☐ No

Are you interested in developing a Mental Health Care Directive (living will)? ☐ Yes ☐ No

Do you have any special difficulty with reading or writing? ______________________________

Do you have any physical disabilities which require that you receive assistance with daily activities?

☐ Yes ☐ No

Do you have any problems that might interfere with your receiving services here at SANFORD HEALTH BEHAVIORAL HEALTH? ☐ Yes ☐ No If yes, please explain: ________________________________
____

Who referred you to SANFORD HEALTH BEHAVIORAL HEALTH?:______________________________

Current Living Situation: ☐ Alone ☐ With relatives ☐ With non-related
Residence: ☐ Shelter/Homeless ☐ Private Residence ☐ Facility ☐ Other__________________

Marital Status: ☐ Married/Committed ☐ Widowed ☐ Divorced ☐ Separated ☐ Single/Never married

People living in the same household:

____
Name Age Relationship M/F Employer Phone
____
Name Age Relationship M/F Employer Phone
____
Name Age Relationship M/F Employer Phone

LEGAL ISSUES
Are you on probation or parole? Yes ☐ No ☐ P.O.: ______________________________
How many charges:_________ Specific Offense:____

Is this evaluation court ordered? Yes ☐ No ☐ If yes, by which county:______________________

Have you been involved in any of the following?
Worker's Compensation claim ☐ Yes ☐ No
Initiating a law suit against another party ☐ Yes ☐ No
Being sued by another party ☐ Yes ☐ No
Commitment for mental health or other reasons ☐ Yes ☐ No
Were any of the charges related to chemical abuse? ☐ Yes ☐ No
Are you currently waiting charges, trial or sentencing? ☐ Yes ☐ No
If yes, what charges? ____

Is there currently an Order for Protection (OFP), No Contact Order or Harassment Order in place from any state on a member of your household? ☐ Yes ☐ No

Has there been an OFP, No Contact Order or Harassment Order from any state placed on a member of your household in the past five (5) years? ☐ Yes ☐ No

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ALCOHOL AND OTHER DRUG INFORMATION

Have you received services for alcohol and/or drug problems in the past? ☐ Yes ☐ No
If yes, where:____
Number of admissions for detoxification: _________ Number of prior admissions for treatment: ______

Alcohol:
☐ Never Used
First Time Used (age):____________First Time Used to Intoxication: ____________________________
Last Use: ______________________Last Used to Intoxication:_________________________________
Frequency and Amount: ____

Marijuana and Other Drug Use:
☐ No Other Drug Use
Other Drugs Used: ______________First Time Used (age): ____________ Last Time Used: _________
Frequency and Amount:____

Misuse or Abuse of Prescription Drugs: ____
Misuse of Abuse of Over the Counter Drugs: ____

Have there been any negative events which have occurred during alcohol or drug use? ☐ Yes ☐ No
If yes, please explain:____

Do you have a supportive family/social network for recovery? ☐ Yes ☐ No
Do you use caffeine? ☐ Yes ☐ No How much: ______________How often:_______________
Do you use tobacco? ☐ Yes ☐ No How much:_______________How often:_______________

Do you have problems with gambling? ☐ Yes ☐ No
If yes, please describe:____

Have you ever felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No
Have you ever had people annoy you by criticizing your drinking or drug use? ☐ Yes ☐ No
Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No
Have you ever had a drink or used drugs as an eye-opener first thing in the morning to steady your nerves or get rid of a hangover, or to get the day started? ☐ Yes ☐ No

CHECKLIST OF CONCERNS

Describe what changes in your life you are seeking by coming to SANFORD HEALTH BEHAVIORAL HEALTH: ____

____

Please mark all of the items below that apply to you. Circle the one that is most important.

- ☐ Stress, coping with daily roles
- ☐ Concern about children, child management, parenting
- ☐ Relationship/family problems
- ☐ Work problems, workaholic, can't keep a job
- ☐ Financial or money worries
- ☐ Self-esteem, sensitive to rejection or criticism
- ☐ Loneliness, withdrawal, isolations
- ☐ Motivation, laziness, procrastination
- ☐ Panic or anxiety attacks
- ☐ Obsessions, compulsions (repeated thoughts/actions)
- ☐ Suspiciousness
- ☐ Delusions (false ideas), thought confusion
- ☐ Judgment concerns: risk taking, impulsivity
- ☐ Anger management, outbursts, aggression
- ☐ Weight and diet issues
- ☐ Menstrual problems, PMS, menopause
- ☐ Sexual issues (dysfunction, conflicts, desire differences)
- ☐ Perpetrator of sexual abuse
- ☐ Grieving, mourning, deaths, losses
- ☐ Other ____________________

Are you currently or have you been treated for any mental health condition? ☐ Yes ☐ No

Where: ____

When: ____

Have you experienced past suicide attempts/thoughts (please describe date and method):

How: ____

When: ____

SANFORD HEALTH

SCHOOL/WORK

Level of Education _________Years: _______ Degree:___________________________________
Current Employment/School: ____
Education and/or Career Goals: ____

MEDICAL

Who is your medical doctor? ____
Are you being seen by an Alternative Healer, if so, who?____________________________

When was your last physical examination? ______________ Results: ___________________
Emergency Room visit in the last year? ☐ Yes ☐ No If yes, why:___________________

Are you allergic to or ever had an adverse reaction to any medications? ☐ Yes ☐ No
If yes, please list: ____
Do you have any other allergies? ☐ Yes ☐ No
For example: foods, airborne ____
Are you pregnant? ☐ Yes ☐ No

Have you ever been treated/experienced any of the following?

- ☐ Ongoing discomfort
- ☐ Chronic Pain
- ☐ Traumatic brain injury
- ☐ Seizures
- ☐ Concussion
- ☐ Loss of consciousness
- ☐ Headaches, migraines
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Chest Pain, palpitation
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Constipation ☐ Diarrhea
- ☐ Problems with appetite
- ☐ Weight loss/gain
- ☐ Diabetes
- ☐ Sexually transmitted disease
- ☐ Other ______________________________

LIST OF SURGERIES THAT YOU HAVE HAD

SURGERY	YEAR

MEDICATIONS

CURRENT MEDICATION	DOSAGE	PRESCRIBER

PAST MEDICATIONS: ____

Do you take vitamins, herbal medications, diet supplements, or other over-the-counter medications?
☐ Yes ☐ No If yes, what type, how much, how long? ______________________________

SYMPTOM CHECKLIST

Symptom	Frequently	Sometimes	Rarely	Never
Do you…				
Have trouble paying attention				
Make careless mistakes				
Not seem to listen when spoken directly to				
Have difficulty following through on instructions				
Struggle to be organized				
Fail to finish tasks or assignments				
Give up when becoming frustrated				
Have trouble concentrating for long periods of time				
Tend to lose many belongings				
Become easily distracted by things going on around you				
Seem to be forgetful				
Fidget and squirm excessively				
Seem to have difficulty staying seated				
Seem to be driven by a motor				
Blurt out answers				
Have difficulty waiting your turn				
Have difficulty with peer relationships				
Interrupts others (e.g. butt into conversations or games)				

Symptom	Frequently	Sometimes	Rarely	Never
Do you…				
Have diminished interest in things you usually enjoy				
Have abnormal changes in your weight				
Demonstrate concerns regarding your eating habits				
Have low energy or seem fatigued				
Have feelings of worthlessness or hopelessness				
Have difficulty making decisions				
Have recurrent thoughts of death				
Think about suicide				
Ever hurt yourself on purpose				
Have difficulty falling or staying asleep				

Symptom	Frequently	Sometimes	Rarely	Never
Do you…				
Have lasting intimate relationships or friendships				
Fear that others will abandon or leave you/quit wanting to be your girlfriend/boyfriend				
Have a “love/hate” relationship with others				
Not have a solid feeling of who you are as a person				
Act in ways that could be harmful (i.e. drinking, sex, spending, binge eating, driving recklessly)				
Cut or threaten/attempt suicide				
Have dramatic changes in mood (i.e. happy then angry then sad all within several hours)				
Feel empty inside				
Have intense anger over small things or difficulty controlling your angry outbursts				
Experience paranoia or feeling as though you are “outside your body” when overly stressed				

SANFORD HEALTH

Have you experienced a traumatic event? ☐ Yes ☐ No
If yes, please explain: ____
____
____

Symptom	Frequently	Sometimes	Rarely	Never
Do you…				
Have excessive fears about bad things happening				
Report physical symptoms when you are trying to avoid something				
Have nightmares regarding the events				
Experience reminders of the event that may trigger stress				
Try to avoid memories, conversations or activities associated with the event				
See or hear things other people don't see or hear				
Find it difficult to control worry				
Feel restless, keyed up, or on edge				
Have sleep disturbances				
Experience irritability or anger outbursts				
Re-experience the event in anyway (flashbacks, images, etc.)				

Consent for Treatment and use of PHI: I acknowledge that I have consented to receive mental health and related services from staff of Sanford Health Behavioral Health which will be described in full in the treatment planning process. I understand that I must consent to receive services or I will not be served.

Client Signature: ______________________________ Date ______________

Parent/Guardian
Signature ______________________________ Date ______________