

**ST. JOSEPH MERCY OUTPATIENT BEHAVIORAL SERVICES**
  
**CONFIDENTIAL INFORMATION FORM for**
  
**ADULTS & ADOLESCENTS**

**(To be completed by patients ages 13 yrs & older)**

- Please answer each question.
- DO NOT LEAVE ANY BLANK AREAS.
- Write NA or put a line through (IF THE QUESTION DOES NOT APPLY TO YOU).
- Discuss question(s) with your therapist if you are unsure/uncomfortable with what is being asked.

*If you need assistance filling out this form due to problems with reading or writing, please ask for assistance.*

Name of assistant filling out the form for the patient: \_\_\_\_\_

**IDENTIFYING INFORMATION**

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Male  Female      Date of birth: \_\_\_\_\_ Age \_\_\_\_\_

**PROBLEM FOR WHICH YOU ARE SEEKING HELP**

\*What problems bring you to the clinic?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When did these problems start? \_\_\_\_\_

How often does this problem occur? \_\_\_\_\_ How long does it last? \_\_\_\_\_

What worsens the problem? \_\_\_\_\_

Why are you seeking help now? \_\_\_\_\_

How have you tried to handle these problems? (Medications, talking, hospitalizations, other?) : \_\_\_\_\_

What strengths/resources do you have? \_\_\_\_\_

**\*CURRENT PROBLEMS/LIFE STRESSORS**

Do you currently have any thoughts of harming yourself?  Yes  No

Do you currently have any thoughts of wishing you were dead?  Yes  No

Do you currently have any urges to hurt, harm, or kill someone else?  Yes  No

If yes, who? \_\_\_\_\_

Have you ever attempted to commit suicide or seriously harm yourself?  Yes  No

If yes, describe: \_\_\_\_\_

Patient Name: \_\_\_\_\_

**\*CURRENT PROBLEMS/LIFE STRESSORS (cont.)**

Do you have any problems or concerns in the following areas? (Check all items that apply.)

- Financial Problems
  - Housing Problems
  - Legal Problems
  - Ability to work
  - Mood
  - Ability to relate to others
  - Health Problems
  - Change in usual attitude to life
  - Use of alcohol/substances/prescription drugs
  - Reckless behavior
  - Physical self-harm or neglect
  - Frequent accidents/injuries
  - Sexual feelings/behavior
  - Ethnic or Cultural Concerns
  - Compulsive behavior (like eating, spending, gambling, shop lifting, Internet surfing)
  - Violent behaviors (like threatening, throwing, breaking, hitting, shoving, hurting)
  - Losses (loved one, job, friend, pet, etc.) Describe: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**\*MENTAL HEALTH/SUBSTANCE ABUSE/COUNSELING HISTORY**

Have you received counseling or therapy in the past for emotional problems or alcohol/drug use? Yes No

If yes, please give details below, beginning with your most recent or current treatment.

Date Began	Date Ended	Therapist/ Psychiatrist	Major Problem Addressed	Satisfied with treatment?

If you were not satisfied with treatment, why? \_\_\_\_\_

\_\_\_\_\_

Have you ever been hospitalized for emotional problems or alcohol/drug abuse? Yes No

If yes, when, where, and for how long? \_\_\_\_\_

**PERSONAL HISTORY**

**Birth and Development**

Were there any problems with your birth and childhood development? Yes No, If yes, check all that apply.

- Speech
- Hearing
- Physical Development
- Emotional Development
- Bladder/Bowel Control
- Learning Problems
- Family Problems (illnesses, deaths, conflicts, abuse, unemployment, etc.)
- Behavior Problems
- School Phobia
- Weight Problems
- Serious Medical Condition
- Other: \_\_\_\_\_

If you checked any of these problems, please describe. Include how long and how treated.

\_\_\_\_\_

Patient Name: \_\_\_\_\_

**Preteen and Teenage Years**

Did you have serious difficulty with any of the following?  Yes  No

If yes, check all that apply.

- Forming Friendships       Dating       Sexuality       Play and Sports  
 Relating to Authority       Family Relationships       Other: \_\_\_\_\_

If you checked any of these areas, please describe:

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**\*Adult Life**

Have you had serious difficulty with any of the following?  Yes  No

If yes, check all that apply.

- Relationships       Sexual Life       Marriage/Dating       Family  
 Work Life       Medical Problems       Other: \_\_\_\_\_

If you checked any of these items, please describe:

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How would you describe your sexual orientation? \_\_\_\_\_

**\*Physical, Emotional, or Sexual Abuse**

Have you ever felt you were the target of *physical* or *emotional* abuse (including threats)?  Yes  No  Unsure

Have you ever felt you were the target of *sexual* abuse (unwanted or inappropriate sexual contact or harassment)?

Yes  No  Unsure

Did any of this occur in the past year?  Yes  No      In childhood?  Yes  No  Unsure

Have *you* ever physically, emotionally, or sexually threatened or hurt someone?  Yes  No  Unsure

If you responded YES to any of the items in this section, please describe as much as you comfortably can:

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**Community Involvement**

How are you involved in your local community? (Check all that apply):

- Use local shops and services (bank, barber/hairdresser, grocery, etc.)       Attend religious/cultural activities  
 Play recreational sport(s)       Coach local children       Volunteer (at local hospital, library, fund drive, etc.)  
 Member of community service group (Kiwanis, Sierra Club, Scouts, etc.)       Involved in community politics  
 Other: \_\_\_\_\_

**Recreation**

What do you do to have fun (hobbies, sports, exercise, etc.)? Please list:

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Patient Name: \_\_\_\_\_

**FAMILY RELATIONSHIPS**

**Family of Origin.** Please list family members, and write in names of any others who also lived with you growing up.

How would you describe your ethnic or cultural background? \_\_\_\_\_

Relationship	Full Name	Age	Sex (M/F)	Living with you now?	If deceased: year, age and cause
Father					
Mother					
Step-father					
Step-mother					
Sibling #1					
Sibling #2					
Sibling #3					

Which family members were you closest to as a child? \_\_\_\_\_

Which family members are you closest to now? \_\_\_\_\_

Do you feel supported by family or friends at this time? Yes No

Check the statement(s) below that best characterize(s) the family you grew up in:

- Overly close family, no breathing room; everyone always in everyone else's business, no privacy, no respect of boundaries.
- Comfortably close, loving, shared many positive experiences, supportive.
- Distant, everyone did their own thing, not much time spent together, not a lot of sharing or support, "every man for himself".
- Angry, there always seemed to be arguments, fighting, verbal abuse, conflicts between everyone, constant battles.
- Frightening, never felt there was support, as if one were standing on thin ice, scared to make mistakes, not sure I could rely on family if I needed help.
- Other Family Type. Describe: \_\_\_\_\_

\*Has anyone in your extended family had any mental health, substance abuse, or emotional problems or diagnosis?

Yes No

If yes, please explain: **(Examples: anxiety, depression, drug or alcohol problems, mood swings, panic attacks, suicide attempts.)**

Relationship to You	Problem(s)	How treated?

Patient Name: \_\_\_\_\_

**Parents**

Who raised you? \_\_\_\_\_

Were you adopted?  Yes  No

Were there problems in your relationship with your father/step-father?  Yes  No

Were there problems in your relationship with your mother/step-mother?  Yes  No

Are you a primary care taker for either of your parents?  Yes  No

Have your parents divorced?  Yes  No If yes, how old were you at the time? \_\_\_\_\_

If either of your parents remarried, how old were you at the time? \_\_\_\_\_

How many different places did you live when you were growing up? \_\_\_\_\_

**Your Marital Status:**  Single  Married/Domestic Partnership  Separated  Divorced  Widowed

Spouse/Partner's Name (begin with most recent)	Date(s) Married	Living with you now?	If Divorced, Separated, or Widowed, Give Date	# Of Children

**Please list your children:**

Child's Name	Age	M/F	Stepchild? Y/N	Living with you now?	Any Problems?

Do you feel children currently under your care are difficult for you to protect or care for?  Yes  No

If yes, please explain: \_\_\_\_\_

Is there anyone else who is currently living with you?  Yes  No

If yes, who? \_\_\_\_\_

**EDUCATION/EMPLOYMENT**

**Education**

Last school grade completed: \_\_\_\_\_ Circle if received: Diploma/GED Year: \_\_\_\_\_

Years of college: \_\_\_\_\_ Degree(s): \_\_\_\_\_ Year(s): \_\_\_\_\_

Are you currently enrolled in school?  Yes  No

If yes, what is your major/focus? \_\_\_\_\_

Do you have any specialty training or skills?  Yes  No

Please list: \_\_\_\_\_

Spouse/partner's education: Last grade completed: \_\_\_\_\_ Year: \_\_\_\_\_ Degree: \_\_\_\_\_

Employment Check all that apply:

Employed  Homemaker  Student  Disabled\*  Unemployed\*  Retired

Patient Name: \_\_\_\_\_

Current employer: \_\_\_\_\_

What are your duties at your job? \_\_\_\_\_

Years on current job: \_\_\_\_\_

If you checked disabled or unemployed, are you on:  Medical Leave  Worker's Compensation?

Last day worked: \_\_\_\_\_ Physician you see for work-related problems: \_\_\_\_\_

What jobs have you held in the past?

Position	Duration	Satisfaction Lo=1...5=Hi	Reason for Leaving

Are you satisfied with your job/career?  Yes  No

If no, please explain: \_\_\_\_\_

Spouse/Partner's occupation: \_\_\_\_\_

**Spiritual/Religious Interests**

If spirituality, religion, or a "higher power" is an important part of your life:

Are you part of a spiritual or religious community?  Yes  No

Optional: What denomination or affiliation? \_\_\_\_\_

\*Do you want your therapist/physician to take your spiritual or religious outlook into consideration in planning your care?

Yes  No

If yes, please describe or give examples: \_\_\_\_\_

**Military History**

Did you serve in the military?  Yes  No

If yes, describe if voluntary/draftee, combat experience if any, awards received, disciplinary actions if any, discharge status, injury while in service if any:

**Legal Status**

Have you ever been involved with the Police or the Courts?  Yes  No If yes, please explain:

Reason for involvement.	Date	Outcome	Was this related to alcohol/drug use?

Patient Name: \_\_\_\_\_

**MEDICAL HISTORY**

How would you describe your general health?  Good  Fair  Poor Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Doctor or clinic that you go to for basic medical care: \_\_\_\_\_  None

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Do you see any other doctors for your healthcare? \_\_\_\_\_

Date of Last Physical: \_\_\_\_\_

Are immunizations complete and up-to-date? (18 and under)  Yes  No  Don't Know

Have you had significant hospitalizations or surgeries?  Yes  No

If yes, list hospitalizations and medical condition necessitating each:

\_\_\_\_\_  
\_\_\_\_\_

\*Have you ever had, or been told that you had: (Check all items that apply.)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Eating disorder            | <input type="checkbox"/> Sleep disorder                              |
| <input type="checkbox"/> Sickle cell disease                           | <input type="checkbox"/> Glaucoma                   | <input type="checkbox"/> Cancer                                      |
| <input type="checkbox"/> High blood pressure                           | <input type="checkbox"/> Stomach ulcers             | <input type="checkbox"/> Diabetes                                    |
| <input type="checkbox"/> Stroke  | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Gout  |
| <input type="checkbox"/> Heart disease                                 | <input type="checkbox"/> Thyroid disease            | <input type="checkbox"/> Tuberculosis (including any positive tests) |
| <input type="checkbox"/> Rheumatic fever                               | <input type="checkbox"/> Kidney disease             | <input type="checkbox"/> Bladder trouble                             |
| <input type="checkbox"/> Asthma or allergies                           | <input type="checkbox"/> Emphysema                  | <input type="checkbox"/> Migraine                                    |
| <input type="checkbox"/> Ulcerative colitis/inflammatory bowel disease |   | <input type="checkbox"/> Concussion/head injury                      |
| <input type="checkbox"/> Epilepsy (seizure disorder)                   | <input type="checkbox"/> Arthritis or joint disease |  |
| <input type="checkbox"/> Hypoglycemia (low blood sugar)                |   | <input type="checkbox"/> Sexually transmitted disease                |
| <input type="checkbox"/> Other: _____                                  |   | <input type="checkbox"/> Possible exposure to HIV/AIDS               |

If you checked any item(s), please describe below (include name of treating physician):

\_\_\_\_\_  
\_\_\_\_\_

**\*Functional Status**

Do you have significant visual impairment/blindness?  Yes  No

Do you have significant hearing impairment/deafness?  Yes  No

Do you have significant motor impairment?  Yes  No

If yes, check:  paraplegic  quadriplegic  wheel chair bound  other \_\_\_\_\_

Do you have a developmental disability?  Yes  No

If yes, please describe: \_\_\_\_\_

Are you able to carry out activities of daily living?  Yes  No

If no, check those you are unable to do.  Feed yourself  Dress yourself  Care for basic hygiene

Get around or go places on your own

Patient Name: \_\_\_\_\_

**\*PRESENT HEALTH**

Please place an X where any apply.

Symptom	Having Current Symptoms? ("X")	Being Treated? Y/N	Name of physician, if being treated.	Office Use Only (Comments / Follow-up Plan)
1. Frequent headaches				
2. Poor memory				
3. Excessive tiredness/weakness/faintness				
4. Vision trouble not corrected by glasses				
5. Hearing difficulties				
6. Dizzy spells				
7. Dental problems				
8. Urinary or bowel difficulties				
9. <sup>H</sup> Unplanned weight loss (not directly related to diagnosis)				
10. <sup>H</sup> Ulcers/Open wounds				
11. <sup>H</sup> Eating less than half usual intake for past seven days or more with presence of nausea, vomiting, constipation, or diarrhea				
12. Laxative overuse				
13. Binge eating				
14. Other: _____				

<sup>H</sup>More than 1 item checked, nutritional assessment referral needed, unless documentation provided indicates referral is not needed.

**Current Medications**

Please list all medications you are currently taking and who prescribed each (please include vaccines, hormones, all over-the-counter and alternative/herbal remedies you are taking and how often).

Name of Medication	Prescribing Doctor's Name or (self)	Dosage & Frequency	For What Condition

Patient Name: \_\_\_\_\_

**\*Physical Pain**

Are you currently experiencing any physical pain? Yes No

If yes,

Where is the location of your pain? \_\_\_\_\_

How would you describe your pain? \_\_\_\_\_

Rate on a scale of 1 - 10 ("1" being no pain and "10" being the worst possible pain) the intensity of your current pain. \_\_\_\_\_ 1-10

Are you currently being treated for your pain? Yes No

If yes, list the name of the treating professional and facility: \_\_\_\_\_

What strategies or treatments have helped you reduce or manage your pain? (Please describe:)  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies**

**Required: Are you allergic to any medications?** Yes No

If yes, to which medications are you allergic? Please list:  
\_\_\_\_\_

Are you allergic to foods, dust, alcohol, or other environmental stimuli? Yes No

If yes, please specify what sets it off and what the reaction is: \_\_\_\_\_  
\_\_\_\_\_

**For Women**

Do you have menstrual cycle difficulties/irregularities? Yes No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Do you have mood changes that seem to be related to your menstrual cycle or to menopause? Yes No

If yes, please describe

\*Are you pregnant now? Yes No Are you planning to be soon? Yes No

Are you nursing? Yes No

**\*SUBSTANCE USE**

Do you use tobacco? Yes No

If yes, please list form and quantity per day: \_\_\_\_\_

Have you tried quitting? Yes No

If yes, what method(s) did you try? \_\_\_\_\_

Do you drink caffeinated beverages? Yes No

If yes, please list kind and quantity per day: \_\_\_\_\_

Have you ever used alcoholic beverages? Yes No

Have you ever used drugs (such as marijuana, cocaine, LSD, heroin, ecstasy)? Yes No

Patient Name: \_\_\_\_\_

If "YES" to either:

Have you ever tried to cut down on your drinking or drug use?  Yes  No

Has your drinking or drug use annoyed anyone?  Yes  No

Do you feel guilty about your alcohol or drug use?  Yes  No

Do you have to use drugs or alcohol to be able to do things?  Yes  No

Do you ever drink or use drugs more than you mean to?  Yes  No

Have you ever not known what you were doing when you were drinking or using drugs?  Yes  No

What drugs do you use, including alcohol? \_\_\_\_\_

How many days a week, on average (for each substance used)? \_\_\_\_\_

About how much do you drink/use drugs in a single day? \_\_\_\_\_

Have you ever taken more of your prescription medication than you were supposed to?  Yes  No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Have you ever overdosed when getting high on alcohol or other drugs?  Yes  No

Has there ever been a period of time when you stopped using alcohol or drugs?  Yes  No

Why did you stop? \_\_\_\_\_ For how long? \_\_\_\_\_

Has your drinking or drug usage ever caused you problems in any of the following areas?  Yes  No

Check all those that apply.

Family  Employment  Legal  Emotional  School

Financial  Behavior  Relationship  Physical/Medical

Other: \_\_\_\_\_

Have you ever been involved in a 12-Step program (such as AA, NA, ALANON)?  Yes  No