Sanford Health Behavioral Health Center

Bemidji
PO Box 640
722 15th St. NW
Bemidji, MN 56601
(218) 751-3280 (office)
(218) 751-3298 (fax)

Park Rapids
109 S. Grove Ave. Suite 1
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Headwaters ACT
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SANFORD HEALTH
Behavioral 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:_____ County of Residence:_____

Address:_____ City:_____ State:_____ Zip:_____

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

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?:_____

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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
Yes, for: _____

☐ Yes ☐ No 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?

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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:_____

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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. <u>Circle the one</u> 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 _____

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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: _____

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

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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

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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				

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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				

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.)				