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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:____

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Behavioral Health

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
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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Behavioral Health

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. 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 ____

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Behavioral Health

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

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? ____

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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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Behavioral Health

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.)				

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Acceptance of Financial Responsibility

Client Name:____ DOB:________________

PLEASE INDICATE HOW THE SERVICES REQUESTED ARE TO BE PAID:

☐ **Bill insurance carrier or other as indicated:**
(Charges for services requested are to be billed to the following sources)

☐ Insurance (primary) Carrier_________________________Group #____________________
Policy #_____________________________ Amount Covered__________________
☐ Insurance (secondary) Carrier_________________________Group #____________________
Policy #____
☐ Medical Assistance MA#____

☐ Consolidated/Date of Funding Assessment/Assessors Name_____________________________

☐ BASC ☐ Prime West ☐ ISD #31 School Grant ☐ Private Pay

I understand that if coverage has lapsed, if the services requested are not covered by the plan, if plan caps have been exceeded, or if the services are denied by the carrier but I wish to have them anyway, **that I will be responsible for the payment.** I also agree to any self-pay amounts indicated by the carrier contract. I authorize SANFORD HEALTH BEHAVIORAL HEALTH to furnish information to the payment sources concerning my illness and treatments and hereby assign to SANFORD HEALTH BEHAVIORAL HEALTH all payments for services rendered to my dependents or myself. This authorization shall remain in effect until otherwise cancelled by Policy Holder or Representative. See the Fee Schedule and Payment Contract for additional terms. I understand that my insurance carrier or other third party payer may inform the "subscriber" of any services billed to the payer.

As a client of Sanford Health Behavioral Health, I agree to the following statements with regard to payment for services:

- Clients are required to pay for services received. A client may choose to bill third party insurance including Medical Assistance and Medicare. In the event that the third party insurance is billed, clients will be required to pay for all services which are not covered by insurance. Exceptions will include those items which are not appropriate to bill the client under the terms of the provider contract.
- If Clients choose to use insurance, they agree to provide insurance information to SANFORD HEALTH BEHAVIORAL HEALTH and agree to assist in billing for insurance reimbursement.
- Self-pay clients are expected to pay for services at that time they are received. Billing arrangements accepted by SANFORD HEALTH BEHAVIORAL HEALTH other than full payment at the time of service are listed below under SPECIAL CONDITIONS.
- If a billing arrangement is made, a minimum payment of $25 per month or 10% of the total bill, whichever is higher, will be expected.
- Interest in the amount of 1.5% of the balance will be charged on accounts which are 60 days in arrears.
- In the event of non-payment, the bill will be sent to collections.
- SANFORD HEALTH BEHAVIORAL HEALTH reserves the right to decline service or to require cash payment if a previous billing arrangement has not been honored.

The client agrees that if circumstances such as income, number of dependents, insurance or eligibility or various programs change, the client will notify SANFORD HEALTH BEHAVIORAL HEALTH. SPECIAL CONDITIONS: ______________________________________

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** ____________________