

**RETURNING CLIENT
ADULT INFORMATION FORM**

Name _____ Date of Appt. _____
 Address _____ City _____ Zip _____
 Telephone Numbers: H) _____ W) _____ Cell) _____
 Is it okay if we leave brief messages at all three numbers? _____
 If not, NO to which one? _____
 Email Address: _____
 Date of Birth _____ Age _____ Sex _____ Married or Life Partner? _____
 Years Married/Living Together _____ Times Married _____

FAMILY MEDICAL & SOCIAL HISTORY:

Have you been hospitalized for anything since your last visit here, including psychiatric inpatient or Intensive Outpatient (IOP)? YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any medications you are currently taking:

Medicine	Dosage	Reason Prescribed
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who are doctors prescribing the above medications: _____

Who is your psychiatrist? _____

Who is your PCP & his/her number? _____

(Primary Care Physician)

May we contact your Psychiatrist and/or PCP to discuss care? YES NO

Please sign for either answer _____

Do you use recreational drugs: YES NO If no: have you used previously? YES NO

If yes, when did you stop? _____

If yes, please list:

Type of Drug	How Much	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you drink alcohol: YES NO If no:have you drank previously: YES NO
If yes: when did you stop? _____

If yes, please list:

<u>Type of Alcohol</u>	<u>How Much</u>	<u>How Often</u>
_____	_____	_____
_____	_____	_____

Describe any important medical history, chronic ailments and other health problems you experience: _____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments: _____

Do you have any close relative (father, mother, brother, sister) who have experienced depression or other emotional problems? Please list: _____

SCHOOL & FAMILY HISTORY: Have you attended or graduated from a school or training program since you were here before? YES NO If yes, please list:

School/Program: _____	Date Completed: _____
MOTHER _____ living	FATHER _____ living
_____ deceased	_____ deceased
_____ married	_____ married
_____ divorced	_____ divorced
_____ remarried _____ #of times	_____ remarried _____ (#of times)

Does the above information represent any changes in your parent's lives or status from before? YES NO If yes, please explain _____

Where do your parents live: Mother _____
Father _____

MARITAL HISTORY: Current marital status: _____ Single/never married
_____ Married _____ Separated _____ Divorced _____ Widowed _____ Living with
someone. If currently married, when were you married? _____ If living with
someone, how long have you lived together? _____ How many times have you
been married? _____.

Please list your children:

<u>Name</u>	<u>Age</u>	<u>Relationship(natural/step)</u>	<u>Lives with</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Others living in the home with you:

NAME RELATIONSHIP AGE GRADE/OCCUPATION

MENTAL STATUS: Please check any of the following that describe how you have been feeling or acting in the last two to six months or related to the reason you are here:

___ sad/depressed ___ anxious ___ panic ___ angry ___ irritable ___ resentful
 ___ worthless ___ tearful ___ jealous ___ hopeless ___ helpless ___ loss of sexual
 interest ___ guilty ___ ashamed ___ loss of interest in activities normally interesting
 or fun ___ low energy ___ extreme mood fluctuations (discrete periods of euphoria &
 high energy followed by periods of deep depression & isolation) ___ aggressive
 ___ thoughts of death ___ loss of concentration ___ phobia(s)

___ obsessive thinking re: _____
 ___ compulsions: _____

___ intrusive thoughts or images ___ frightened ___ hypervigilance
 Describe any other feelings you have had or elaborate on any checked from above:

Have you had any change in sleeping habits? YES NO Describe

Have you had any change in your appetite? YES NO

Describe _____

Has there been weight loss ___ or gain ___? How much? _____ In what time span? _____

Have you ever considered suicide in connection to your **current** problems? YES NO

If so, please give a brief description with dates:

Have you ever **considered** suicide in the **past**? YES NO

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

X _____ **Date** _____

I authorize the payment of medical benefits to the provider of services.

X _____ **Date** _____

PLEASE READ THE FOLLOWING CAREFULLY:

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. Heritage Behavioral Health will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

I realize that I will be charged \$75.00 for appointments not cancelled within 24 hours of the appointment time.

Signature _____ **Date** _____