



Center for Wellness and Recovery

an Affiliate of Mountain View Hospital

FIND YOUR DIRECTION

2141 CORONADO ST. IDAHO FALLS, ID 83404 / (208)-523-3857

*Please complete this form and bring to your first appointment.

This information is fundamental to the assessment and treatment process.

PATIENT CONTACT INFORMATION

Name _____ Age _____ Date of birth _____

Phone (____) _____ Mailing Address _____

Emergency contact name _____ Relationship to emergency contact _____ Phone (____) _____

PRESENTING PROBLEMS AND CONCERNS

Describe the concern that brought you here today: _____

What has led you to seek help for this concern at this time? _____

Have you already tried to resolve this concern? If so, what did you do and how did it work? _____

Who do you go to for support (family, friends, faith or spirituality, support or self-help groups)? _____

Please check all of the behaviors and symptoms that you consider problematic:

- | | | |
|--|---|---|
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Suspicion/Paranoia |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Lack of motivation | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Withdrawal from people | <input type="checkbox"/> Excessive energy |
| <input type="checkbox"/> Boredom | <input type="checkbox"/> Anxiety/Worry | <input type="checkbox"/> Wide mood swings |
| <input type="checkbox"/> Poor memory/Confusion | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Seasonal mood changes | <input type="checkbox"/> Fear away from home | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Sadness/Depression | <input type="checkbox"/> Social discomfort | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Loss of pleasure/Interest | <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Gambling problems |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Compulsive behavior | <input type="checkbox"/> Computer addiction |
| <input type="checkbox"/> Thoughts of death | <input type="checkbox"/> Aggression/Fights | <input type="checkbox"/> Problems with pornography |
| <input type="checkbox"/> Self-harm behaviors | <input type="checkbox"/> Frequent arguments | <input type="checkbox"/> Parenting problems |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Irritability/Anger | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Homicidal thoughts | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Low self-worth | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Work/School problems |
| <input type="checkbox"/> Guilt/Shame | <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Alcohol/Drug use |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Visual hallucinations | <input type="checkbox"/> Recurring, disturbing memories |
| <input type="checkbox"/> Other: | <input type="checkbox"/> Other: | <input type="checkbox"/> Other: |

Are your problems affecting any of the following?

- | | | | |
|--|--|--|-----------------------------------|
| <input type="checkbox"/> Handling everyday tasks | <input type="checkbox"/> Self esteem | <input type="checkbox"/> Relationships | <input type="checkbox"/> Hygiene |
| <input type="checkbox"/> Work/School | <input type="checkbox"/> Housing | <input type="checkbox"/> Legal matters | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Recreational activities | <input type="checkbox"/> Sexual activity | <input type="checkbox"/> Health | <input type="checkbox"/> Other: |

SAFETY CONCERNS

Have you ever thought about hurting or killing yourself, or had an impulse to do so? Yes No

If yes, do you have a suicide plan? Yes No

If so, please explain: _____

If you have a plan, do you have the intention of acting on your plan? Yes No

If so, please explain: _____

What are your reasons for living? _____

Have you ever tried to hurt or kill yourself? Yes No

If yes, list the date(s), method(s) and how you were rescued: _____

Have you ever harmed property or other people or thought seriously about causing harm to someone? Yes No

If yes, please explain: _____

Are you having thoughts of harming someone right now? Yes No

If yes, please explain: _____

Are there firearms in your home? Yes No

How many and of what type (pistol, revolver, rifle, automatic)? _____

Do children or teens have access to these firearms? Yes No

Are these firearms stored unloaded and locked with trigger guards? Yes No (Trigger guards are free of charge from local police departments)

Is the ammunition (bullets) kept in a separate location? Yes No

Have you recently been physically hurt or threatened by someone else? Yes No

If yes, please describe: _____

Have you told anyone about the safety concerns above? Yes No

If yes, who: _____

If you have told someone, what did you tell them and what was their response? _____

If you have not told someone, why not? _____

FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Age	Quality of Relationship	Family Mental Health History	Who?
Mother				Major Depressive Disorder	
Father				Bipolar Disorder	
Stepmother				Posttraumatic Stress Disorder	
Stepfather				Obsessive Compulsive Disorder	
Siblings				Schizophrenia	
				Eating Disorder	
				Alcohol Abuse	
				Drug Abuse	
Spouse/partner				Personality Disorder	
Children				Suicidal Action/Completion	
				Victim of Abuse	
				Abusive/Domestic Violence	
				Other:	

Please check the item that best describes you below:

- Single Married Remarried Partner or significant other
 Separated Divorced Widowed Other:

Please describe your living situation. Check all that apply:

- With spouse With partner or significant other With children With parents
 Alone With roommate Other:

Please check most appropriate description of parental marital status:

- Parents legally married or living together Mother remarried Number of times _____
 Parents temporarily separated Father remarried Number of times _____
 Parents divorced or permanently separated

Please check if you have experienced any of the following types of trauma or loss:

- Emotional abuse Neglect Lived in a foster home
 Sexual abuse Violence in the home Multiple family moves
 Physical abuse Crime victim Homelessness
 Parent alcohol or substance abuse Parent serious illness Loss of a loved one
 Teen pregnancy Placed a child for adoption Financial problems
 Military related trauma Abortion Other:

PREVIOUS MENTAL HEALTH TREATMENT

		Type of Treatment	When?	Provider/Program	Reason for Treatment
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Outpatient psychotherapy			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric medication			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric hospitalization			

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Addiction treatment			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Self-help/Support groups			

SUBSTANCE USE HISTORY

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
PCP/LSD								
Spice								
Bath Salts								
Prescription Pain Medications								
Prescription Anxiety Medications								

Yes No Have you had withdrawal symptoms when trying to stop using any alcohol or any other substances? If yes, please describe:

Yes No Have you ever had problems with work, relationships, health, the law, etc. due to your alcohol or substance use? If yes, please describe:

MEDICAL INFORMATION

Do you have a primary care clinic or medical provider? Yes No

Name of clinic or provider _____

Phone (_____) _____ Fax (_____) _____

Have you had a physical exam to check for medical reasons for your symptoms? Yes No

Date of your last physical exam _____

Have you experienced any of the following medical conditions during your lifetime?

- | | | | |
|---|-------------------------------------|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Surgery | <input type="checkbox"/> Serious accident | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> High fevers | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Abortion | <input type="checkbox"/> Sleep disorder | <input type="checkbox"/> Other: |

Please list any CURRENT medical concerns: _____

Do you have a psychiatric provider? Yes No

Name of provider _____

Phone (_____) _____ Fax (_____) _____ Date of last visit: _____

If so, why are you seeking services at our center? _____

Current prescription medications: None

	<u>EXAMPLE</u>	Medicine #1	Medicine #2	Medicine #3	Medicine #4	Medicine #5	Medicine #6
Name of medicine	Celexa						
How many milligrams (mg)?	40 mg						
How many pills do you take at a time?	one						
How many times a day do you take this medicine?	once						
What time of day do you take this medicine?	morning						
What does this medicine treat?	depression						
Name of prescriber	Dr. John Smith						

If you need more space, please attach another sheet of paper.

Current over-the-counter medications (including vitamins, herbal remedies, etc.): _____

Allergies and/or adverse reactions to medications: None

If yes, please list:

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your social support network (check all that apply):

- Family Neighbors Friends Students/Co-workers
- Support/Self-Help Group: _____ Community Group: _____
- Religious/Spiritual Group: _____ Cultural/Ethnic Group: _____

If you are experiencing any difficulties due to interpersonal, social or cultural issues, please describe: _____

How important are interpersonal, social, or cultural issues matters to you?

- Not at all Very little Somewhat Very Much

Would you like these perspectives and concerns to be incorporated into your services? Yes No

Please describe your strengths, skills and talents? _____

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.): _____

MISCELLANEOUS INFORMATION

Employment

Employer: _____ Position: _____

Length of time in this position: _____ Job Duties: _____

Stress level of this position: Low Moderate High Other positions you have held: _____

Education

Are you currently attending school? Yes No

- H.S. Diploma or GED? Year _____ If not, why not: _____
- Associate's Degree Year _____ Major area of study _____
- Undergraduate Degree Year _____ Major area of study _____
- Graduate Degree Year _____ Major area of study _____

Do you have learning difficulties in any of these areas?

- Speech Hearing Reading Writing
- Concentration Attention Math Other:

Military Service

Have you been/are you currently in the military? Yes No (If no, skip remainder of this section)

Branch _____ Date of Discharge _____ Type of Discharge _____ Rank _____

Were you in combat? Yes No

If Yes, does this experience adversely impact your functioning today? Yes No

Are you service connected for any type of disability? Yes No

Legal

Have you ever been convicted of a misdemeanor or felony? Yes No If yes, please explain: _____

Are you currently involved in any divorce or child custody proceedings? Yes No If yes, please explain: _____