Mountain View Hospital
CENTER FOR WELLNESS & RECOVERY

*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:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/Confusion
- ☐ Seasonal mood changes
- ☐ Sadness/Depression
- ☐ Loss of pleasure/Interest
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self-worth
- ☐ Guilt/Shame
- ☐ Fatigue
- ☐ Other:

- ☐ Change in appetite
- ☐ Lack of motivation
- ☐ Withdrawal from people
- ☐ Anxiety/Worry
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Aggression/Fights
- ☐ Frequent arguments
- ☐ Irritability/Anger
- ☐ Homicidal thoughts
- ☐ Flashbacks
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Other:

- ☐ Suspicion/Paranoia
- ☐ Racing thoughts
- ☐ Excessive energy
- ☐ Wide mood swings
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Eating problems
- ☐ Gambling problems
- ☐ Computer addiction
- ☐ Problems with pornography
- ☐ Parenting problems
- ☐ Sexual problems
- ☐ Relationship problems
- ☐ Work/School problems
- ☐ Alcohol/Drug use
- ☐ Recurring, disturbing memories
- ☐ Other:

Are your problems affecting any of the following?

☐ Handling everyday tasks	☐ Self esteem	☐ Relationships	☐ Hygiene
☐ Work/School	☐ Housing	☐ Legal matters	☐ Finances
☐ Recreational activities	☐ Sexual activity	☐ Health	☐ 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
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/partner			
Children			

Family Mental Health History	Who?
Major Depressive Disorder	
Bipolar Disorder	
Posttraumatic Stress Disorder	
Obsessive Compulsive Disorder	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	
Personality Disorder	
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
☐ Yes	☐ No	Outpatient psychotherapy			
☐ Yes	☐ No	Psychiatric medication			
☐ Yes	☐ No	Psychiatric hospitalization			

☐ Yes	☐ No	Addiction treatment			
☐ Yes	☐ 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? Ifyes, 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?

☐ Allergies	☐ Asthma	☐ Headaches	☐ Stomach aches
☐ Chronic pain	☐ Surgery	☐ Serious accident	☐ Head injury
☐ Dizziness/Fainting	☐ Meningitis	☐ Seizures	☐ Vision problems
☐ High fevers	☐ Diabetes	☐ Hearing problems	☐ Miscarriage
☐ Sexually transmitted disease	☐ Abortion	☐ Sleep disorder	☐ 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

	EXAMPLE	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 thatapply):

☐ 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: _____

_____

_____