SANFORD HEALTH
Behavioral Health

- 722 15th Street NW, PO Box 640 • Bemidji, MN 56619-0640 (218) 751-3280 office, (218) 751-3298 fax
- Headwaters ACT Team: 408 Beltrami Ave NW, #2 (218) 444-4429 office, (218) 444-5491 fax
- 109 S. Grove Ave. Ste. 1 • Park Rapids, MN 56470 (218) 732-7266 office, (218) 237-8276 fax

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:_____ OK to call? ☐Yes ☐No Work Phone:_____ OK to call? ☐Yes ☐No Cell Phone:_____ 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?:_____

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

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?

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: _____

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 _____