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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 UMMHC 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

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 UMMHC?  Yes  No

If yes, please explain: \_\_\_\_\_

Who referred you to UMMHC?: \_\_\_\_\_

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: \_\_\_\_\_

**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 UMMHC:

\_\_\_\_\_  
 \_\_\_\_\_

**Please mark all of the items below that apply to you. Circle the one that is most important.**

- |  |   |
|--|---|
| <input type="checkbox"/> Stress, coping with daily roles                     | <input type="checkbox"/> Suspiciousness   |
| <input type="checkbox"/> Concern about children, child management, parenting | <input type="checkbox"/> Delusions (false ideas), thought confusion                 |
| <input type="checkbox"/> Relationship/family problems                        | <input type="checkbox"/> Judgment concerns: risk taking, impulsivity                |
| <input type="checkbox"/> Work problems, workaholic, can't keep a job         | <input type="checkbox"/> Anger management, outbursts, aggression                    |
| <input type="checkbox"/> Financial or money worries                          | <input type="checkbox"/> Weight and diet issues                                     |
| <input type="checkbox"/> Self-esteem, sensitive to rejection or criticism    | <input type="checkbox"/> Menstrual problems, PMS, menopause                         |
| <input type="checkbox"/> Loneliness, withdrawal, isolations                  | <input type="checkbox"/> Sexual issues (dysfunction, conflicts, desire differences) |
| <input type="checkbox"/> Motivation, laziness, procrastination               | <input type="checkbox"/> Perpetrator of sexual abuse                                |
| <input type="checkbox"/> Panic or anxiety attacks                            | <input type="checkbox"/> Grieving, mourning, deaths, losses                         |
| <input type="checkbox"/> Obsessions, compulsions (repeated thoughts/actions) | <input type="checkbox"/> Other _____  |

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: \_\_\_\_\_