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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

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 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: _____