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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 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
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Name	Age	Relationship	M/F	Employer	Phone
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Name	Age	Relationship	M/F	Employer	Phone
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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. Circle the one 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 _____