

**Capstone Behavioral Healthcare
Adult Information Form**

Date: _____ Social Security # _____

Last Name: _____ **First Name:** _____ **MI** _____

Street Address: _____ Apt or Box #: _____

City _____ State _____ ZIP _____ County _____

Home Phone Number (_____) _____ Cell Phone Number (_____) _____

Work Phone Number (_____) _____ Date of Birth ___/___/____ Gender Male Female

Employer: _____ Address: _____

Highest grade or Degree Completed: _____ Are you a U.S. citizen? Yes No

Do you have any current legal involvement? Yes No _____

Referred by: Self Hospital Family/Friend School Court Physician
 DHS Probation Officer Other _____

Reason for Referral: Mental Health Substance Abuse OWI/Zero Tolerance Domestic Abuse

Marital Status: Never Married Married Divorced Widowed Separated Other _____

Ethnicity: White/Caucasian African American Hispanic American Indian
 Asian/Pacific Islander Other: _____

Employment Status: Full time Part time Unemployed/looking for work Student Retired Disabled
 Other: _____

Emergency Contact: _____ Relationship to Client: _____ Phone: _____

FAMILY/HOME INFORMATION

How many dependents do you have? (Include yourself) _____

<u>Children</u>	<u>Age</u>	<u>Living at Home?</u>

List other people living in the home besides those named above:

<u>Name</u>	<u>Age</u>	<u>Relationship</u>

Do you currently reside in a: Residential program Correctional Facility Nursing Home

(Continued)

MEDICAL/HEALTH INFORMATION

Have you received mental health treatment before? Yes No

If so, when and where _____

Do you use: Tobacco? Alcohol? Drugs?

Have you been treated for alcohol/drug problems before? Yes No

If so, when and where _____

Briefly describe the problem that brings you to Capstone today:

Please check any of the following that you have experienced recently:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Voices/visions | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Paranoia | <input type="checkbox"/> Appetite problems | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Compulsive behaviors | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Running away |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Too much energy | <input type="checkbox"/> Poor attention | <input type="checkbox"/> Social withdrawal |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Distractibility | <input type="checkbox"/> Irritability | <input type="checkbox"/> Low energy |
| <input type="checkbox"/> Aggression/violence | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Blackouts | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Other(s) _____ | | |

Do you have any current or ongoing medical problems? Yes No

If so, please explain: _____

Who is your primary doctor/medical provider?

Name City Phone number

Should we contact your doctor? Yes No

Which pharmacy do you use? _____ Phone _____

What medications do you take? (include non-prescription, herbal medicines and supplements)

Medicine	Dose	Frequency	Who prescribes
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any allergies, including medication allergies/sensitivities:
