|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  | Initial Information | Date: |  |  |
|  | Change \* | Date: |  |  |
|  | Discharge | Date: |  |  |
|  |  |  |  |  |



Mental Health Information

|  |  |  |  |
| --- | --- | --- | --- |
| **Client Name** | **Date of Birth** | **OHP ID** | **PCP** |
|  |  |  |  |

Your patient is receiving services at our agency

If you have questions or want additional information, including the assessment or treatment plan, please contact:

|  |
| --- |
| **Clinician/Therapist/Case Manager/Service Coordinator** |
| Choose an item. |

|  |
| --- |
| **Presenting Issues/Diagnosis** |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medications** | | | | | |
| Prescriber: |  | Tel: |  | Email: |  |
| Medication | | Dosage/Frequency | | Prescribed to Address . . . | |
|  | |  | |  | |
|  | |  | |  | |
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| --- |
| **\* Describe Change(s)** |
|  |

If you patient is receiving psychiatric medications, we will stabilize them appropriate to their condition. Once your patient is on a stable medication regimen, we will contact you to discuss transitioning them back to you for continued prescribing of their psychotropic medications. We will continue to be available for consultation and support and immediate return to services if you patient’s needs change.

Note: Please fax ongoing lab results and/or medication changes to us for coordination of care.

**Marion County Behavioral Health-Health History**

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| --- | --- | --- | --- |
|  |  |  |  |
| Client Name | RT# | Date of Birth | Age |

|  |
| --- |
| **Who is your primary care provider?** Name: |

|  |  |  |
| --- | --- | --- |
| Address: | Phone: | Last Visit: |

|  |
| --- |
| **Do you exercise? If so, what type and how often?** |

|  |
| --- |
| **What do you do to relax?** |

|  |
| --- |
| **Do you use tobacco? If so, how much?** |

|  |
| --- |
| **Do you use alcohol or drugs? If so, how much/how often?** |

|  |
| --- |
| **List any surgeries you have had:** |
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| --- |
| **Do you have any allergies to medications?**­­­­­­­­­­­­­­­ |

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| --- |
| **Is there anything else you would like to add?** |
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|  |

**Symtoms that you are currently experiencing:**

Easily distracted  Bingeing or purging  Sexual problems

Difficulty focusing  Feeling nervous/anxious  Lack of motivation

Trouble concentrating  Feeling fearful  Excessive energy  Gambling problems  Feelings of panic  Thoughts of hurting/killing yourself

Sadness  Loss of pleasure/interest  Cutting/self-harm behaviors

Sleep Problems  Feeling Hopeless  Lack of energy/fatigue

Seasonal mood changes  Obsessing  Compulsive spending  Nightmares  Feelings of extreme happiness  Racing thoughts

Flashbacks  Seeing things or hearing voices  Alcohol or drug problems

Eating problems  Suspicion or paranoia

**Are your problems affecting any of the following?**

Handling everyday tasks  Work or school  Living situation

Recreational activities  Legal matters  Relationships

Finances  Health

(Feel free to use the other side of this form if more room is needed)

**History of other Mental Health Providers:**

Issue: Whom did you see? When?

|  |  |  |
| --- | --- | --- |
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(Feel free to use the other side of this form if more room is needed)

**Has anyone in your family been treated for mental health concerns?**

Issue: Relationship to you:

|  |  |
| --- | --- |
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**Please list any medications you have taken in the past to help you with your mental health concerns:**

Medication Dose Purpose Stopped because

|  |  |  |  |
| --- | --- | --- | --- |
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**Please list any medications you are taking now (include prescription and over-the-counter meds, herbals, supplements, for both medical and mental health reasons):**

Medication Dose Purpose Who prescribed/recommended?

|  |  |  |  |
| --- | --- | --- | --- |
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**Medical History (check if yes):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Personal History? Dates:  From To | | Family History? | Relationship to You |
| Thyroid Disease |  |  |  |  |
| Liver Disease |  |  |  |  |
| Head Trauma |  |  | NA | NA |
| Seizures or Epilepsy |  |  |  |  |
| Stroke |  |  |  |  |
| Heart Disease/Attack |  |  |  |  |
| Obesity |  |  |  |  |
| High cholesterol/lipids |  |  |  |  |
| High Blood Pressure |  |  |  |  |
| Stomach Problems |  |  |  |  |
| Asthma |  |  |  |  |
| Lung Problems |  |  |  |  |
| Kidney Disease |  |  |  |  |
| Cancer |  |  |  |  |
| Pain |  |  |  |  |
| Diabetes |  |  |  |  |
| Anemia |  |  |  |  |
| LMP (women) |  |  | NA | NA |
| Hearing or Vision problems |  |  |  |  |
| Headaches |  |  |  |  |
| Other Illnesses? |  |  |  |  |

**Developmental History (check if yes):**

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Received Prenatal Care |  |  |
| Birth Complications |  |  |
| Recurring infections |  |  |
| Scabies/Lice/Rashes |  |  |
| In-utero Exposure to Alcohol/Drugs |  |  |
| Developmental targets on time |  |  |
|  |  |  |
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Your Signature Date

ABH TEAM REFERRALS

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Client Name:** | |  | | | **ID#:** |  |
|  | | | | | | |
| **DOB:** |  | | | **Level of Care:** | | |
|  | | | | | | |
| **QMHA Assigned:**  **Contact phone number:**  **ISSP Complete Yes  No**  **Med Intervention? Yes  No** | | | | | | |
| **Initial Appointment Given: Yes  No Rxer:**  **Prescriber Intake Appointment Date:       Time:** | | | | | | |
| **Additional Notes:** | | |  | | | |

**Assigned Service Coordinator:**

|  |  |
| --- | --- |
| Barlow, Bobbi | Stainbrook, Leslie |
| McNab, Ami | Nowak, Kelly |
| Collins, Jenny | Jeffers, Crystal |
| Castleton, Laura | Thiel, Gailene |
| Hunter, Miki |  |
| Joque, Barbara |  |
| Linton, Jennifer |  |
| Musillami, Allison |  |
| Neuhart, Minet  O’Connor, Cari  Barrios, Daisy  Tucker, Marlene  Maceira, Anna  Chun, Jennifer | Intern: |

|  |
| --- |
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|  |  |  |  |
| --- | --- | --- | --- |
| ACT | AOP | PSRB | BHDD |
|  | | | |
| ECOS |  |  |  |

Intake Worker Date

|  |  |
| --- | --- |
| Date of Transfer: | By (Initials): |

Changes made to:  Raintree  IPA  H:Drive/Client folders

|  |
| --- |
|  |