Iowa Specialty Hospitals & Clinics

Behavioral Health Services Patient Form

PATIENT INFORMATION **Today's date: ____/____/____**

Legal Last name:	**MI:**	**Legal First Name:**
Name:	**Insurance:**	**Date of Birth:**

Address:	**Home Phone:**
Address (PO Box, Apt #):	**Cell Phone:**
City:	**County:**
State/Zip:	**Email:**
Gender: **Pronouns:** He/Him/His She/Her/Hers They/Their/Theirs Other:______	**Ethnicity:** ☐ Not Spanish, Hispanic, Latino or Mexican ☐Puerto Rican ☐ Mexican ☐ Cuban ☐Other Hispanic or Latino ☐Unknown
Race: ☐ White ☐ Black/African American ☐ American Indian ☐ Asian ☐Alaskan Native ☐ Hawaiian or Pacific Islander ☐Unknown	**Location for Therapy (check all that apply):** ☐ Belmond ☐ Clarion ☐ Garner ☐ Hampton ☐ Webster City ☐ Telehealth **Male/Female Therapist:** ☐ Male ☐ Female ☐ Either

Referral Source (circle all that apply): Court Ordered *State Probation/Parole *Federal Probation/Parole
*DHS Employer Hospital Self-Referral OWI/Zero Tolerance Other:__________________________
*DHS Worker Name:_________________________________ *PO Worker Name: _____________________________________

Communication Method: Communication Device Sign Language Verbal
Spoken & Written Language: English Spanish Other:______________________
Last Grade Completed:______________________ ☐High School Diploma ☐GED ☐College

Emergency Contact

Last name:	**MI:**	**First Name:**

Address:	**Phone:**
City/ State/Zip:	**Relationship to you:**

Demographic Information

Relationship status: ☐Single ☐Married ☐Cohabitating ☐Separated ☐Divorced ☐Widowed
Name of Partner:
How is your relationship?
Does anyone in your household currently use alcohol or drugs?
Does anyone in your household have a mental health condition?
Sexual Orientation (heterosexual, gay, lesbian, questioning, etc.):
Pregnant: ☐ Yes- Due Date: ☐ No

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Are there any other living environment or family issues that you would like to address? ☐ **No** ☐ **Yes**

____

Family Information

Child Name	DOB/Age	Relationship to patient?	How is the relationship?	Lives in the home?

Were you adopted? ___________________________________ If yes, at what age? ______________________
Were your parents divorced? ___________________________________ If yes, how old were you? ____________

Military Family and Deployment

Have you served in the military or armed forces? (Air Force, Army, Coast Guard, Marines, Navy, National Guard, or Reserves) ☐No ☐ Yes ☐ Prefer not to answer

If "yes" in which of the following have you ever served? Please answer for each of the following. You may say yes to more than one.

Branch of service	Yes	No	Prefer not to answer
Armed Forces	☐	☐	☐
Reserves	☐	☐	☐
National Guard	☐	☐	☐

Are you currently serving on active duty in the Armed Forces, the Reserves, or the National Guard?
☐No ☐Yes ☐ Prefer not to answer

If "yes" in which of the following have you ever served? Please answer for each of the following. You may say yes to more than one.

Branch of service	Yes	No	Prefer not to answer
Armed Forces	☐	☐	☐
Reserves	☐	☐	☐
National Guard	☐	☐	☐

Have you ever been deployed to a combat zone? ☐ No ☐ Yes ☐ Prefer not to answer

Is anyone in your family or someone close to you currently serving on active duty in or retired/separate from the Armed Forces, the Reserves, or the National Guard? ☐ No ☐ Yes ☐ Prefer not to answer

Are you involved in the VA ☐ No ☐ Yes

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Reason for Seeking Help:

How would you rate your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Reason for seeking services: ☐ Mental Health ☐ Substance Use

What is your reason for seeking help? ____

When did this start? ____

Have you previously suffered from this complaint: ____

Current Stressors: ____

Current Health Care Providers

Name of Primary Care Physician:	Practice Facility Name and City:
Primary Care Physician:	
Name of Dentist:	
Name/Specialty of Specialist:	
Name/Specialty of Specialist:	
Psychiatric Medication Provider:	
Name of previous therapist:	

Current Symptoms (Check All That Apply & List All Others)

☐ Anxiety	☐ Appetite Changes	☐ Avoidance	☐ Crying Spells
☐ Depression	☐ Excessive Energy	☐ Fatigue	☐ Guilt/Shame
☐ Excessive Stress	☐ Impulse Behavior	☐ Difficulty Concentrating	☐ Helplessness
☐ Loss of Interest	☐ Panic Attacks	☐ Racing Thoughts	☐ Risky Activity
☐ Sleep Disturbance	☐ Trust Issues	☐ Flashbacks	☐ Memory Issues
☐ Nightmares	☐ Hallucinations	☐ Paranoia	☐ Anger/Irritability
☐ Intrusive Thoughts	☐ Loss Of Control	☐ Delusions	☐ Hopelessness
☐ Repetitive Behaviors	☐ Obsessive Thoughts	☐ Suicidal thoughts	☐ Isolating
☐ Low Motivation	☐ Loneliness	☐ Poor Self Care	☐ Homicidal thoughts
☐ Self-Injury	☐ Binge Eating	☐ Restricting Food	☐ Purging
☐ Job Stress			

Current Medications

Medication Name	Dose and Frequency	Reason	How long & Effectiveness

Allergies: ____

Infectious Disease (Diagnosed or Suspected) and STD Risk

Disease or Exposure	No or N/A	Past	Current	Receiving/ ed treatment
Hepatitis Type				
HIV or AIDS (optional)				
IV drug use				
Tuberculosis (TB)				
TB Exposure				
Sexually Transmitted Disease (STD)				
Sexual Contact without barrier protection				
Blood transfusion				
Yellow jaundice				
Share needles/work				
Exchange sex for money or drugs				
Been involved in a sexual assault				

Hospitalizations:

Date:	Reasons:

Do you have a Durable Power of Attorney for Healthcare Decisions/Psychiatric Advance Directive?

☐ **No** ☐ **Yes**

If you do not have a Durable Power of Attorney for Healthcare Decisions/ Psychiatric Advance Directive, would you like more information about how to secure one?

☐ **No** ☐ **Yes**

Substance Use History

Substance of Use	Age of First use & Last date of use	Pattern of Use within last 6 months	Method of Use

Past Substance use disorder treatment: ____

____

Family History of Substance use: ____

____

Tobacco use

Do you use tobacco? ☐ No ☐ Yes

Would you like assistance to quit? ☐ No ☐ Yes

Education

Highest level of education: ____

Were you bullied in school? ____

How did you do socially in school? ____

How did you do academically in school? ____

Employment

Employer	Estimated hire date	Estimated End date	Job duties/ Reason for leaving/ Comments

Legal

In the past 30 days, how many times have you been arrested	○ ___________ times ○ Don't want to answer ○ Don't know
Is this assessment court ordered? Do you have a pending court date?	☐ No ☐ Yes- If yes, what county? ☐ No ☐ Yes- If yes, when is your court date?
Is this assessment for OWI or Zero Tolerance Offense? BAL? ________ If yes, was an accident involved?	☐ No ☐ Yes ☐ No ☐ Yes

Are you on probation?	☐ No ☐ Yes
Are you involved with Department of Human Services?	☐ No ☐ Yes

Trauma/Abuse History

Exposure (experienced or witnessed)	No or Not applicable	Past	Current	Receiving/ ed treatment
Experience or witness physical abuse				
Experience or witness emotional abuse				
Experienced or witness sexual abuse				
Experience or witness domestic abuse				
Traumatic experiences (could include childhood experiences, loss, car accident, violence, war, sexual assault, neglect, natural disaster or anything that was overwhelming to you)				

Strengths and Goals

What are your strengths? ____

What are your goals for treatment? ____

What would you like to change/work on? ____

Anything else you want the provider to know?

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