A member of the **Seton** Healthcare Family

		PAT	IENT INFO	RMATION			
Last Name:			First Na	ıme:			M.I
Date of Birth:		Age:	Socia	Security #:			
Sex:	Gen	der:			Race:		
Relationship Status:	☐ Never Married	☐ Married	☐ Legally	Separated	Divorced	☐ Widowed	☐ Partnered
Address:							
City:		Sta	te: (County:		Zip	:
Home Phone:				May we lea	ave a message?	☐Yes	□No
Cell Phone:				_ May we lea	ave a message?	☐Yes	□No
Employer:							
Employer's Address:							
City:		Stat	e:	Zip:	Phone: _		
Occupation:							
Employment Status:	☐ Full-time ☐ F	Part-time 🔲 U	Jnemployed	☐ Self-em	ployed	red 🗌 Studen	t
	PRIMA	RY INSURAI	NCE CARD	HOLDER II	NFORMATION		
\square Same as above							
Last Name:			First Na	ıme:			M.I
Date of Birth:/	/ Soc	cial Security #:			Rel	ationship:	
Primary Cardholder's	Address:						
City:		State: _	Zip:		Phone: _		
Employer:							
Employer's Address:							
City:		Stat	e:	Zip:	Phone: _		
Occupation:							
Cardholder's Employ	ment Status: 🔲 I	Full-time	Part-time	Unemplo	yed Self-er	nployed 🔲	Retired
		EMERGENC	Y CONTAC	CT INFORM	IATION		
1) Name:					_Relationship:		
Home Phone:				Cell Phone:			
Work Phone:				_ Other:			
O) Nove					Date: 11		
2) Name:					·		
Home Phone:							
Work Phone:				Other:			

Behavioral Health Assessment

Part 2-Patient Self Report

In order for us to better understand your needs, please complete this form as completely as possible. If you have questions about completing this form, please ask at the Check In desk. Thank you!

Current = experienced in the last two weeks

History = experienced at some point in your life

BEHAVIORS		Current	History			Current	Histo	ry	
Increased isolat Aggressive beha Indecisive Nervous tics Sexually comput Sexual abstinen Take too many Can't keep a job Phobic avoidance Crying Compulsions Unmotivated Procrastination Talkative	avior Isive ice risks			Work too I Poor conc Impulsive Loss of co Outbursts Thoughts Suicide at Self-injury Double ch Sleep dist Insomnia Nightmare Eating pro Startle eas	entration reactions introl of temper racing tempts ecking thing urbances es iblems	gs			
FEELINGS	Current	History		Current	History			Current	History
Angry Depressed Guilty Jealous Ashamed Critical Confident Insecure Annoyed Energetic Happy Lonely Relaxed Ecstatic Unhappy Worthless			Empty Proud Anxious Envious Helpless Optimistic Restless Frightened Exhausted Bored Excited Hopeful Panicky Frustrated Misunderstor			Sad Suspiciou Driven Conflicted Fearful Hopeless Trapped Tense Enraged Confused Contented Self-cons Hypersen Overwhel Regretful Detached Powerful	d cious sitive med		

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Clinician Initials_____



Behavioral Health Assessment

Part 2-Patient Self Report

☐ Yes ☐ No	Have you had previous psychiatric treatment?							
	If yes, how many times? Inpatient	Outpatient						
	Please describe your most recent treatment below:							
	Where?							
	When?							
	What were you treated for?							
☐ Yes ☐ No	Have you had previous chemical dependency treatment?							
	If yes, how many times? Inpatient	Outpatient						
	Please describe your most recent treatment below:							
	Where?							
	When?							
	What were you treated for?							
☐ Yes ☐ No	Have you gone through withdrawal from a substance in the past?							
	Which substance?							
	When?							
☐ Yes ☐ No	Did you get medical attention?							
	If yes, where?							
☐ Yes ☐ No	Do you have a current psychiatrist?							
	If yes,							
	Name:							
	How long have you been seeing them?							
	When did you last see them?							
☐ Yes ☐ No	Do you have a current therapist?							
	If yes,							
	Name:							
	How long have you been seeing them?							
	When did you last see them?							

INTENSIVE OUTPATIENT PROGRAM



Name:	
Admit Date:	
Prescribing Physician(s):	

Please write your initials next to each medication you are taking this week. If you have a new medication or a new dose of an existing medication, please write it at the bottom of the list. PLEASE DO NOT CROSS OUT MEDICATIONS OR DOSES! Ask your group leader if you have questions about this form.

, , , , , , , , , , , , , , , , , , ,	(-)			_ <u> </u>	have questions about this form.				
Medication	Dose	Schedule	Week 1 Date:	Week 2	Week 3	Week 4	Week 5	Week 6	
example			Initial that you are taking rhis medication this week	Mark with an X if you are this medication/dose this	no longer taking week				
Prozac	10 mg			<u> </u>					
		_	_						
		_							
		_							
		_							
		_	_						
		_							
		_							
		_							
									
		_							
		_							
		Patien	t (sign)						
	Clini		e/time)						
	Pnysi	cian (sign/dat	e/time)						