Seton Mind Institute
BEHAVIORAL HEALTH SERVICES
A Department of Seton Shoal Creek Hospital
A member of the Seton Healthcare Family

PATIENT LABEL

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I. _____

Date of Birth: _____/_____/_____ Age: _____ Social Security #: _____-_____-_____

Sex: _____ Gender: _____ Race: _____

Relationship Status: ☐ Never Married ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed ☐ Partnered

Address: _____

City: _____State: _____ County: _____ Zip: _____

Home Phone: _____ *May we leave a message?* ☐*Yes* ☐*No*

Cell Phone: _____ *May we leave a message?* ☐*Yes* ☐*No*

Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Occupation: _____

Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Self-employed ☐ Retired ☐ Student ☐ Other

PRIMARY INSURANCE CARDHOLDER INFORMATION

☐ **Same as above**

Last Name: _____ First Name: _____ M.I. _____

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____ Relationship: _____

Primary Cardholder's Address: _____

City:_____ State: _____Zip: _____ Phone: _____

Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Occupation: _____

Cardholder's Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Self-employed ☐ Retired

EMERGENCY CONTACT INFORMATION

1) Name:_____Relationship:_____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Other: _____

2) Name:_____Relationship:_____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Other: _____

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Behavioral Health Assessment **Part 1-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!

Has been a problem in the last two weeks:	Has been a problem during my lifetime:	
☐	☐	Worry
☐	☐	Avoiding others
☐	☐	Fear of being out in public
☐	☐	Restlessness
☐	☐	Irritability
☐	☐	Trouble concentrating
☐	☐	Double checking things
☐	☐	Thinking about the same thing over and over
☐	☐	Too many unwanted thoughts
☐	☐	Upsetting dreams
☐	☐	Avoiding thoughts or feelings about an upsetting event
☐	☐	Avoiding people or places that remind me of an upsetting event
☐	☐	Loss of interest in activities
☐	☐	Feeling separate from others
☐	☐	Anger outbursts
☐	☐	Crying
☐	☐	Feeling depressed
☐	☐	Sad mood
☐	☐	Feeling empty
☐	☐	Hopeless feelings
☐	☐	Feeling oversensitive
☐	☐	Confusion
☐	☐	Loss of energy
☐	☐	Increased energy
☐	☐	Feeling guilty
☐	☐	Thoughts of suicide
☐	☐	Feeling happier than normal
☐	☐	Racing thoughts
☐	☐	Impulsive behaviors
☐	☐	Overspending
☐	☐	Increased sex drive
☐	☐	Decreased sex drive

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? _____

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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.

Medication	Dose	Schedule	Date:	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6
example				Initial that you are taking this medication this week	Mark with an X if you are no longer taking this medication/dose this week				
Prozac	10 mg	morning		JD	X				
			Patient (sign)						
			Clinician (sign/date/time)						
			Physician (sign/date/time)						