NORTHAMPTON COUNTY MENTAL HEALTH
2801 Emrick Boulevard
Bethlehem, PA 18020
610-829-4840

This history form is designed to give you an opportunity to provide us with a wide variety of background information. Please read the questions carefully and answer them as frankly as possible. The information will help us to help you. Completion of this form is considered the first step in the evaluation and treatment process. By answering these questions in advance, our staff will be able to spend more time during the initial interview discussing the issues that are most important to you, as you begin mental health treatment. This information will be kept in complete confidence. Thank you for taking the time to complete this document.

CONFIDENTIAL

FOR PROFESSIONAL USE ONLY

Date of Intake: _____

NAME: _____ DATE OF BIRTH ___ / ___ / ___

SPOUSE'S/PARTNER'S NAME: _____ DATE OF BIRTH ___ / ___ / ___

ADDRESS:_____
(Number, Street, Apt. #) (City, State) (Zip Code)

PHONE: Home _____ Work _____ Other _____

(May we phone you at work? Yes _____ No _____)

CURRENT AGE: _____ E-mail: _____

SEX: Male _____ Female _____ MAIDEN NAME (if applicable) _____

SOCIAL SECURITY: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ CITIZENSHIP: _____

EMPLOYER'S NAME (S) & ADDRESS (ES): (Also include all other sources of income)

ESTIMATED ANNUAL FAMILY INCOME: _____

MEDICAL INSURANCE (S): (Fill in company names plus group and agreement numbers)

* * * * **The bottom of this page is for office use only.** * * * *

CASE NUMBER: _____ INTAKE WORKER _____

Briefly describe the reason(s) why a mental health appointment has been scheduled.
(Use backs of pages for any answers that require more space.)

How long has this been a problem? _____

Who referred you to our agency? _____

If you have ever seen a psychiatrist, psychologist, social worker, counselor, member of the clergy, family doctor, etc., for this, or for similar problems, please list the following:

Professional's Name/Address	Dates seen (from /to)	Problem
1.		
2.		
3.		
4.		
5.		

If you have ever been hospitalized for psychiatric or medical conditions, please list the following:

Hospital's Name/Address	Dates seen (from /to)	Problem
1.		
2.		
3.		
4.		
5.		

If you have had prior mental health treatment, what type of therapy, services, and/or medications did you find to be the most helpful?

What new approaches or services do you feel would be of the most help to you, if those services are available? (Respite care, consumer movement, support groups, drop-in-center, intensive case management, outpatient therapy, etc.)

MEDICAL HISTORY

Please check all of these that you have now and/or have had in the past. If it occurred in the past, please indicate the age when it was happening.

Pres.	Past	Age		Pres.	Past	Age	
_____	_____	_____	crying spells	_____	_____	_____	arthritis
_____	_____	_____	head injury	_____	_____	_____	asthma
_____	_____	_____	headaches	_____	_____	_____	back problems
_____	_____	_____	fainting / dizziness	_____	_____	_____	bed-wetting / soiling
_____	_____	_____	seizures	_____	_____	_____	bladder problems
_____	_____	_____	unconsciousness	_____	_____	_____	bowel problems
_____	_____	_____	loss of appetite	_____	_____	_____	cancer
_____	_____	_____	weight gain / loss	_____	_____	_____	diabetes
_____	_____	_____	high fevers	_____	_____	_____	heart trouble
_____	_____	_____	hives / rashes	_____	_____	_____	hepatitis / jaundice
_____	_____	_____	blood pressure (high / low)	_____	_____	_____	kidney trouble
_____	_____	_____	chest pain / pressure	_____	_____	_____	liver trouble
_____	_____	_____	shortness of breath	_____	_____	_____	rheumatic fever
_____	_____	_____	gynecological problem	_____	_____	_____	stomach problems
_____	_____	_____	premenstrual syndrome	_____	_____	_____	stroke
_____	_____	_____	nightmares	_____	_____	_____	thyroid problems
_____	_____	_____	night sweats	_____	_____	_____	tuberculosis
_____	_____	_____	pos. test for AIDS antibody	_____	_____	_____	unusual bleeding
_____	_____	_____	sexual dysfunction	_____	_____	_____	other _____
_____	_____	_____	skin problems	_____	_____	_____	other _____

Please use this area to comment on any of the items listed above, and on any other serious accidents, operations, or illnesses:

Please check the following if it applies to you and describe details in the space provided:

_____ Sleep Difficulties — Details:
- _____ can't fall asleep
- _____ can't stay asleep through the night
- _____ wake up too early
- _____ sleeping too much

_____ Eating Difficulties — Details:
- _____ eating too much
- _____ eating too little
- _____ binge eating and/or purging

_____ Difficulties maintaining a daily routine — Details:

Please list the name(s), address(es), and phone numbers of the family doctor(s) or clinic(s) you use most often:

Please list the names and addresses of any other doctors you are seeing/have seen:

1.

2.

3.

Please give the name, address, and phone number of the drug store you use:

If you have any allergies, please describe them here:

If you have ever used tranquilizers, antidepressants, or other medications for mental health related problems, please list them here:

Please list all medications (prescriptions, over-the-counter, herbal) you are using now, including dosages and times:

If you have had any bad reactions or side effects from medications, please note the medication(s) and problems here:

Please describe any especially frightening or disturbing events that you have experienced, such as automobile accidents, fires, deaths, violence, crime victimization, and illnesses:

FAMILY HISTORY

	Name	Age	Occupation	Lives in…(city/state)
Father				
Mother				
Bros& Sisters				

Please use this space to comment on your family while you were growing up, noting any rough spots, such as parental separation/divorce/remarriage, and if someone other than your natural parents raised you, note the name(s):

If you have lived in any foster homes or residential placements, please list the name(s) and address(es):

Check any of the following that occurred (or are occurring now) in your family and give a brief description of those checked in the space below:

1. Physical abuse _____
2. Violent arguments/fighting _____
3. Child abuse _____
4. Sexual abuse _____
5. Chronic illness _____
6. Alcohol abuse _____
7. Drug abuse _____
8. Suicidal behavior _____
9. Involvement with a cult _____
10. Involvement with a gang _____

If any members of your family have been treated for mental or emotional problems, or substance abuse issues, please explain the circumstances here:

MARITAL AND SOCIAL HISTORY

Current Relationship Status:

Single	_____	Separated	_____
Married	_____	Divorced	_____
Living with Someone	_____	Widowed	_____
Dating	_____		

Please provide some information about your past and present relationships with others and note any current relationship problems you may be having:

If you have children, please list the following information:

	Name	Age	Lives with…	School grade/occupation
1.	_____	___	_____	_____
2.	_____	___	_____	_____
3.	_____	___	_____	_____
4.	_____	___	_____	_____
5.	_____	___	_____	_____
6.	_____	___	_____	_____
7.	_____	___	_____	_____

Please list the names, ages, and relationships to you of those currently living with you and not listed above, including all family members, friends, and so on.

Name	DOB/Age	Relationship		Name	DOB/Age	Relationship

Please check what language(s) is (are) spoken and/or written in your home?

English: _____ spoken _____ written

Spanish: _____ spoken _____ written

Other Language(s): _____ _____ spoken _____ written

_____ _____ spoken _____ written

If you are actively involved in church, temple, mosque, or other spiritual activities, please give the name of this organization and a brief description of the activities:

What do you enjoy doing in your spare time? Include hobbies, interests, and anything else that helps you relax.

Do you feel you make friends easily? Yes _____ No _____

Briefly describe any difficulties you may have in dealing with people:

EDUCATIONAL HISTORY

Highest school grade completed? _____ GED? Yes _____ No _____

	School Name	Address	Degree	Year
High School				
College				
Grad. School				

Please list any other specialized education/training you have received:

If you had any trouble in school with either academic subjects or behavior, please describe the problem(s) here:

If you received any special awards or honors in school, please note them here:

OCCUPATIONAL HISTORY

Present occupation & employer: _____

How long have you had this job? _____

Please describe the nature of your duties/responsibilities and note any recent changes that have been stressful (include promotions, demotions, awards, or any disciplinary actions):

If your current mental health problems or medications are interfering with job performance, please comment upon that here:

How well do you get along with fellow workers? _____

How well do you get along with supervisor(s)? _____

How many different jobs have you held in the last five years? _____

What other jobs have you held since you began working?

Please list any specialized job training you have received or skills you have mastered:

If you are interested in vocational training or rehabilitation services, please note that here and give us an idea of the services you might like, if available:

How would you describe yourself in relationship to spending, saving, and managing money?

MILITARY HISTORY

Have you ever been in the military? Yes _____ No _____

If yes, which branch? _____ Officer or enlisted? _____

Length of service? (month and year) From _____ To _____

If you were honored or promoted while in the service, please explain here:

If you were disciplined or demoted while in the service, please explain here:

If you were in treatment while in the service, please explain here:

Do you have a “service connected” disability? Yes _____ No _____

If yes, please explain here:

Date and type of discharge:

MISCELLANEOUS

If you use tobacco, how much and what type do you use daily?

If you have ever used alcohol, when, where, how much, and what type do you (did you) drink?

If you have ever used street drugs (marijuana, cocaine, LSD, etc.) or abused prescription medications, please list the following:

Type of drug	Amount	Frequency	Most Recent Usage

If you have ever been treated for substance abuse, please list the name(s) and address(es) of the treatment sites(s):

Name/Address	Dates (From /to)	Problem
1.		
2.		
3.		
4.		
5.		

If you consume caffeine (in coffee, tea, colas, etc.), how much do you consume daily?

Do you have any history of aggressive behavior? Yes _____ No _____
If so, please describe:

Do you have any history of fire setting? Yes _____ No_____
If so, please describe:

If you have ever been arrested, please check all that apply:

Juvenile arrest record	Yes _____	No _____
Adult arrest record	Yes _____	No _____
Currently on probation	Yes _____	No _____
Currently on parole	Yes _____	No _____

If on probation/parole, list the name, address, and phone number of the P.O.:

If applicable, please describe the arrest record here:

If you are involved with any other agencies/services or you are trying to apply for benefits, please check them off (or add them) below and fill in the name and phone number of the contact person:

Agency/Service	Contact Person	Phone Number
_____ Adult Education (_____)	_____	_____
_____ Children & Youth Services (_____)	_____	_____
_____ CHIPPS, ICM, or RC (_____)	_____	_____
_____ Clubhouse (_____)	_____	_____
_____ Consumer Organization (_____)	_____	_____
_____ Drop-in-Center (_____)	_____	_____
_____ Drug & Alcohol (_____)	_____	_____
_____ Law Suits/Legal Action (_____)	_____	_____
_____ Mental Health Program (_____)	_____	_____
_____ Public Assistance (or Medical Assistance)	_____	_____
_____ Social Security (e.g. SSD or SSI)	_____	_____
_____ Support Group (_____)	_____	_____
_____ Veteran's Administration	_____	_____
_____ Workman's Compensation	_____	_____
_____ Other (_____)	_____	_____

Please comment on any of these issues here:

Who is aware you are beginning mental health services? (e.g. family, friends, and/or employer)

If others are aware, what is their attitude about it?

What strengths can you list that will help in resolving the issues you have noted?
(e.g., family supports, friendships, personal insights, faith, etc.)

Please explain what type(s) of transportation you use: (Do you drive, take buses, or have other transportation available?)

Please list any times of the day, or days of the week, when you cannot make it in to the clinic for appointments:

If someone helped you fill out this form, please write his or her name and phone number here:

Please review your answers and, if there is anything else you feel would be important, please include it here:

Thank you for taking the time to fill out this form.