

JOHNSON
COUNTY

MENTAL
HEALTH
CENTER

Suite 130
6000 Lamar Ave.
Mission, KS 66202
(913) 831-2550

NORTHEAST—
Suite 130
6000 Lamar Ave.
Mission, KS 66202
831-2550

SOUTHWEST —
1125 W. Spruce
Olathe, KS 66061
782-2100 (V/TDD)

ADULT INFORMATION RECORD

(age 18 and older)

Dear Friend:

On the next three pages we ask for information that will help us choose the person who will work with you, and allow your therapist to prepare for your first visit.

It will also take care of most of the needed paperwork so you will not have to spend time when you come into the office completing forms.

Our basic aim is to help you enhance and strengthen your personal and family life. We are all faced, from time to time, with situations in which we become frustrated, discouraged, and unable to cope in a way that brings growth and satisfaction. We may become confused, depressed, tense, frightened, and lose self-confidence during these times of stress.

Your therapist will help you work on treatment goals that can be achieved within a few visits. Some problems require more than a few sessions, but many can be resolved rather quickly. We want to provide the service you need, so please be as open and direct as possible with your therapist.

Discussing personal matters may be a little awkward and embarrassing at first. We will do our best to be supportive and encouraging, and **will keep all information in strict confidence.**

Sincerely,

Ronald D. McNish, Ph.D.

Ronald D. McNish, Ph.D.
Director of Clinical Services

If you need help with this form, please call the Mental Health Center for assistance.

Johnson County Mental Health Center does not discriminate on the basis of race, color, national origin, sex, religion, age, and handicapped status in employment or the provision of services.

Individuals who need auxiliary aids for effective communication or who have other special needs are encouraged to notify the Mental Health Center of their requirements.

Confidential Information

Today's Date: _____

Name _____ Birthdate _____ Age _____ Sex: M F
(Full Legal Name) Social Security Number

Address _____
Street City Zip Code

Home Phone _____ Work Phone _____ Work Hours _____

May we leave a message on your home phone? Yes No May we leave a message at your work? Yes No

Person to notify in case of emergency _____ Phone Number _____

Check one: Never Married Married Separated Divorced Remarried Widowed Living Together

If married, how long? _____ Name of spouse _____ Previous Married/Maiden Name(s), if any _____

How many children do you have? _____ Names and birthdates of children living with you _____

Education – Highest grade/degree _____ Employment status: Unemployed Part-time Full-time Retired

If employed, what type of work do you do? _____

What is your Race? Check all that apply: White Black/African Amer. North/South Amer. Indian Asian Pacif. Islander Other

Are you of Latin or Hispanic ethnicity? Yes No

Are you a Veteran? Yes No If yes, did the V.A. refer you here? Yes No Do you have a V.A. fee basis card? Yes No

Do you have a disability? Yes No If yes, what is the disability? _____

Do you have an SRS Medical Card? Yes No Do you have Medicare coverage? Yes No

Do you have a Federal Black Lung card? Yes No

Is the condition that brings you here related to an accident of any kind? Yes No

If yes, was it: Work Related Auto Injured in your own home Other Please explain _____

Name of insurance company _____ Phone Number _____

Group/Plan Number _____ ID Number _____

Name of insurance policy holder _____ Social Security Number _____

Policy holder's employer _____

Do you have a second insurance policy? Yes No If yes, list name of company _____

Please list any previous mental health care you have received:

<u>Name of Facility</u>	<u>City and State</u>	<u>Type of Care</u>	<u>Month and Year</u>
_____	_____	_____	From _____ to _____
_____	_____	_____	From _____ to _____
_____	_____	_____	From _____ to _____
_____	_____	_____	From _____ to _____

How did you learn about the Mental Health Center? _____

What health problems do you have, if any? _____

What chronic or severe illnesses and surgeries have you had and when? _____

What severe accidents have you had and when? _____

Name and Address of Primary Care Physician (PCP):

Last Name _____ First Name _____ Phone _____

Street: _____ City _____ St and Zip _____

Have you had a visit/check-up with your PCP in the past 12 months? Yes No

Do you have regular preventative health screens? Yes No

List medicines, both prescribed and non-prescribed you have taken in the past 6 months:

Medicine	Dosage	For What Problem?	Was It Effective?	Taking It Now?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

List any other medicines you have taken in the past for nervous or emotional problems:

Medicine	When?	Who Prescribed?	For What Problem?	Was It Effective?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What medicines are you allergic to, if any? _____

Do you smoke cigarettes? Yes No Frequency _____ Amount _____

Do you drink alcohol? Yes No Frequency _____ Amount _____

Circle below each type of drug which you have used in the last 12 months:

Marijuana Stimulants/Speed Cocaine/Crack Hallucinogens/Acid Depressants/Downers Heroin Inhalants

Have you ever been treated for alcohol or drug dependence? Yes No If yes, When _____

How often do you drink alcohol? Daily Weekly Less often Do you currently participate in AA or NA? Yes No

Do any members of your family have alcohol/drug problems? Yes No

If yes, which family members? _____

PROBLEMS AND STRESSES

Please describe the problems you are experiencing. _____

About how long have these problems been troubling you? _____

Please describe what led to your decision to seek counseling now. _____

Below is a list of common stresses that may occur during anyone's life. Each of these can be important in leading to physical and/or emotional difficulties because they involve change and change may cause stress. **Please place a checkmark beside each event that has occurred in your life during the past twelve months.**

- | | |
|--|---|
| <input type="checkbox"/> Death of spouse | <input type="checkbox"/> Death of a close friend |
| <input type="checkbox"/> Marital separation | <input type="checkbox"/> Change in number of marital arguments |
| <input type="checkbox"/> Jail term (yourself or others close to you) | <input type="checkbox"/> Mortgage or loan over \$10,000 |
| <input type="checkbox"/> Death of close family member | <input type="checkbox"/> Foreclosure of mortgage or loan |
| <input type="checkbox"/> Personal injury or illness | <input type="checkbox"/> Change in work responsibilities |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Son or daughter leaving home |
| <input type="checkbox"/> Fired from work | <input type="checkbox"/> Outstanding personal achievement |
| <input type="checkbox"/> Marital reconciliation | <input type="checkbox"/> Spouse begins or stops work |
| <input type="checkbox"/> Retirement | <input type="checkbox"/> Trouble with boss |
| <input type="checkbox"/> Change in family member's health | <input type="checkbox"/> Change in work hours/conditions |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Change in residence |
| <input type="checkbox"/> Sex difficulties | <input type="checkbox"/> Change in sleeping habits |
| <input type="checkbox"/> Addition to family | <input type="checkbox"/> Change in number of family gatherings |
| <input type="checkbox"/> Business adjustment | <input type="checkbox"/> Change in eating habits |
| <input type="checkbox"/> Change in financial status | <input type="checkbox"/> Minor violation of the law |
| | <input type="checkbox"/> Change in use of alcohol and other drugs |

What other important events have occurred in your life during the last six months? _____

SATISFACTIONS

How many good close relationships do you have with family and relatives? _____

How many close friends do you have? _____ What are you most proud of accomplishing? _____

What interests or hobbies do you enjoy? _____

How much satisfaction do you get from your work? Very much Some Very little

How much satisfaction do you get from your family? Very much Some Very little