CENTRACARE
St. Cloud Hospital

Date Completed: ____________________

BACKGROUND INFORMATION FORM

ADULT BEHAVIORAL HEALTH

Instructions: To help us offer you the highest quality service, please fill out this form as fully and openly as possible. This information is held in **strict confidence** within legal limits.

BASIC INFORMATION:

Name: _________________________ __ Preferred Name: _________________ Age: _____ Date of Birth:________

ETHNIC ORIGIN:

____African American _____Asian _____Caucasian _____Hispanic _____Native American

____Other: (please note) __________________________

RELATIONSHIP STATUS:

__Single __Dating __Married __Separated/Divorced __Widowed __Remarried __Partnered

AREAS OF CONCERN:

Please describe problems/concerns for which you are seeking help:

____

____

____

____

____

PREVIOUS MENTAL HEALTH CARE RECEIVED: Please indicate below what the **treatment** was for (e.g. depression, anxiety, etc.), the **approximate date** the treatment started (it's ok to estimate), the name of the treatment **facility or provider**, the **type of care** you received (e.g. individual therapy, family/couples therapy, hospitalization, etc.), the **outcome** of treatment (poor, fair, good, excellent, etc.) and **how long** treatment lasted.

Treatment For	Year started	Facility and Provider	Type of Care	Outcome	How Long did you receive treatment?

*C-SSRS (If yes to any of 1-3, provider please administer the complete SSRS)

1. Have you ever wished you were dead or wished you could go to sleep and not wake up?* ___Yes ___No
2. Have you actually had any thoughts of killing yourself?* ___Yes ___No
   a. If **yes**, please answer the following questions:
      i. Have you been thinking of how you might kill yourself? ___Yes ___No
      ii. Have you had these thoughts and had some intention of acting on them? ___Yes ___No
      iii. Have you started to work out or worked out the details of how to kill yourself? ___Yes ___No
         1. Do you intend to carry out this plan? ___Yes ___No
3. Have you ever done anything, started to do anything, or prepared to do anything to end your life?* ___Yes ___No

a. If **yes**, how long ago did you do any of these?*

___ within the last 3 months ___between 3 months and 1 year ago ___ over a year ago

4. Do you currently engage in self-harm (i.e., cutting, burning self) or have thoughts of doing this? ___Yes ___No

5. Do you have thoughts of harming someone else? ___Yes ___No

<u>SUBSTANCE USE AND ADDITIVE BEHAVIORS:</u> *CAGE-AID

1. Do you drink alcohol?* ___Yes ___No
  - **a.** If **yes**, how often? ____
    - i. Approximately how much each time? ___________________________
    - ii. When was the last time that you drank? _________________________
  - b. If **no**, have you drank alcohol in the past? ___Yes ___No
    - i. If **yes,** when is the last time that you drank? _________________________

2. Do you use street drugs (including, but not limited to cocaine, meth, marijuana)? ___Yes ___No
  - a. If **yes**, what kind? ____
    - i. How often? ____
  - b. If **no**, Have you ever experimented with drugs?* ___Yes ___No
    - i. If yes, when is the last time that you used? _________________________

3. Do you use tobacco products? ___Yes ___No
  - a. If **yes**, what kind (cigarettes, chew, e-cigs, etc.)? _________________
    - i. How often? ____
    - ii. Would you like information on how to quit? ___Yes ___No

4. Have you ever misused prescription medications? (e.g. pain pills or anxiety pills) ___Yes ___No
  - a. If **yes**, what have you used and when?____

5. Do you use any other chemicals to obtain a high? (e.g. synthetic drugs, bath salts, etc)? ___Yes ___No
  - a. If **yes**, what have you used and when?____

6. Are drugs or alcohol causing you problems at present? ___Yes ___No
  - a. If **yes**:
    - i. Have you ever felt you ought to cut down on your drinking *or drug use*?*___Yes ___No
    - ii. Have people annoyed you by criticizing your drinking *or drug use*?* ___Yes ___No
    - iii. Have you ever felt bad or guilty about your drinking *or drug use*?* ___Yes ___No
    - iv. Have you ever had a drink *or used drugs* first thing in the morning to steady your nerves or to get rid of a hangover?* ___Yes ___No

7. Has alcohol or drug use caused any problems in the past? ___Yes ___No
  - a. If **yes**, what kind of problems? ____

8. Have you ever been in chemical dependency treatment? ___Yes ___No
  - a. If **yes**, how many times, for what chemical, and when? ____
  - b. Did you successfully complete each program? Explain: ____

9. Do you consume caffeinated beverages? ___Yes ___No
  - a. If **yes**, what beverage, how much, and how often? ____

10. Do you gamble? ___Yes ___No
  - a. If **yes**, how often? ____daily ____weekly ____monthly ____occasionally
  - b. Have you ever lost more money than you could comfortably afford? ___Yes ___No

11. Do you find that you spend more money while shopping (either in person or online) than you could comfortably afford? ___Yes ___No
  - a. If **yes**, how often? ____weekly ____monthly ____occasionally

12. Do you spend an excessive amount of time on the internet, so much so that it distracts from your ability to complete daily required task (i.e., self-care, work, child care, sleep? ___Yes ___No
  - a. If **yes**, how often? ____weekly ____monthly ____occasionally

<u>CURRENT LIFE SITATION:</u>

1. ***Current Family Information:***
   a. Are you currently in a committed relationship? ___Yes ___No
      i. If so, what is your significant other's name? ____________________________ Their Age _______
   b. Are you currently married or partnered? ___Yes ___No
      i. If **yes**, how long have you been married/partnered? (_______years)
      ii. Type of relationship: ___Close ___Conflicted ___Supportive ___Distant ___Neutral
      i. Comments ____
   c. If you are separated, divorced or widowed, how long has it been? (_________years)
   d. How many times have you been married? (_________times)
   e. If you have children, please complete the following (add a page if you need more room):

Child's Name	Age	Gender	Child lives with me: Yes	No	If "No", who does he/she live with and where?
		M or F			
		M or F			
		M or F			
		M or F			
		M or F			

   f. Have you had any miscarriages or stillbirths? Yes_____ No_____
      How many? _____ When? ________________

2. **Current Living Arrangements:**
   a. Please describe your current living situation, (e.g. own home, rent an apartment, living with friends/family, retirement community, group home, homeless in a shelter, etc.) _____________________
   b. **Nature of current family relationships:** ___Close ___Conflicted ___Supportive ___Distant ___Neutral
      i. Comments ____
   c. Are you satisfied with your living situation? ___Yes ___No
      i. If **no**, please explain: ____
   d. **Besides any children and/or spouse listed above, *who else lives in your home?***

Person's Name	Age	Relationship To You

3. **Family History:**
   a. Were your parents separated or divorced? ___Yes ___No
      i. If **yes**, how old were you when that occurred? ______
   b. Describe the relationship between your parents: (check all that apply):
      ___Healthy ___Loving ___Supportive ___Neutral ___Distant ___Conflicted
      ___Abusive ___Other: __________________
   c. Do you have any siblings? ___Yes ___No
      1. If **yes**, how many brothers? ________ How many sisters? _________
         a. Your place in birth order: ____
   d. Other important family information or events that you would like your provider to know: ______________
      ____

4. **Current Life Relationships:**
   a. Friendships/Support System: ___Many ___Few ___None
   b. Nature of Relationship: ___Supportive ___Draining __Other: _____________________
   c. Comments ____

5. **Legal Issues:**
   a. Are you currently involved in any legal difficulties (e.g. DWI, divorce, lawsuit, custody dispute, felony, probation, traffic, etc.) ___Yes ___No
      i. If **yes**, briefly describe your difficulties: ____

      ____
   b. Have you had any other legal problems in the past? ___Yes ___No
      i. If **yes**, briefly describe your difficulties: ____

      ____

6. **Cultural and Spiritual Factors:**
   a. Do you identify with any specific religious, spiritual or cultural affiliation? If so, what? _______________
   b. Do you participate in any religious, spiritual or cultural practices (such as church, pow-wow, culturally specific activities)? ___Yes ___No
      i. If **yes,** What practices? ____________________How often? ______________________
   c. Additional comments: ____

7. **Education:**
   a. Years of schooling (0 to 16+) ____
   b. Diploma or highest degree received: ____
   c. Any history of learning difficulties: ___Yes ___No
      i. If **yes**, please check all areas of difficulty you have experienced in the area of learning:
         ___Concentration ___Hearing ___Listening ___Reading ___Writing
         ___Memory ___Other
      ii. Comments: ____
   d. Have you ever been diagnosed with a learning disorder? ___Yes ___No
      i. If **yes**? By Whom? _________________ When? _____________________
      ii. Type: ____

8. **Employment:**
   a. Are you currently employed? ___Yes ___No
      i. If **yes**, where?____
      ii. What is your job title?____
      iii. Comments ____
   b. Work Environment:
      ___Challenging ___Stressful ___Supportive ___Rewarding ___Unhealthy
      ___Not applicable ___Other

   c. Any history of difficulties with employment? ___Yes ___No
      i. If yes, please explain:____

      ____
   d. Do you currently receive Social Security benefits? _____ Yes _____No ______Applying
      i. Reason: ____

9. **Military Service:**
   a. Have you served in the military? ___Yes ___No
      i. If **yes**, when? From ______________ __ to ________________
         1. What branch of service? ____
         2. Highest rank obtained: ____
         3. Type of Discharge: ____

MEDICAL OVERVIEW:

1. PRIMARY CARE CLINIC:
   ___CentraCare ___St. Cloud Medical Group ___Williams Integracare ___Health Partners
   ___Other: ________________

2. Primary Care Provider: ____

3. Psychiatric (Mental Health Medication) Provider: ____

4. Please list current and past **medical conditions** (Please use comments section on back page if needed)

Condition(s)

5. Have you ever:
   a. Had a concussion? ___Yes ___No
      i. If **yes**, list how many and what caused them? ______________________________________
         1. Did you receive medical treatment after? ___Yes ___No
   b. Had a loss of consciousness? ___Yes ___No
      i. If **yes**, list how many and what caused them? ______________________________________
         1. Did you receive medical treatment after? ___Yes ___No
   c. Had a seizure?
      i. If **yes**, list how many and what caused them? ______________________________________
         1. Did you receive medical treatment after? ___Yes ___No
6. Developmental Issues:
   a. Mother's approximate age when she had you: _________________
   b. Any complications that she had with her pregnancy, labor or delivery with you? ___Yes ___No
      i. If **yes,** please explain: ____
   c. Any developmental issues that you had? (e.g. slow to walk, talk, potty train) ___Yes ___No
      i. If **yes,** please explain: ____

7. Please list all current **medication(s)** and the reason they are prescribed:

Medication	Purpose

8. Please list any **allergies**, and the type of reactions you have (e.g. rash, nausea, trouble breathing).

Allergy to what?	Type of Reaction

9. Are there any <u>medical</u> conditions in your immediate family (including your biological family, as well as in your own family and children): ___Yes ___No
   a. If **yes**, please describe: ____

<u>FAMILY MENTAL HEALTH AND CHEMICAL HISTORY:</u> For each condition listed below, please identify any <u>immediate family member</u> who has experienced the condition:

1. Alcohol or Drug Use (list type of use): ____
   ____
2. Anxiety: ____
   ____
3. Bipolar Disorder: ____
   ____
4. Depression (including any suicide attempts or completions): ____
   ____
5. Eating Disorder: ____
   ____
6. Learning Disorder/Cognitive Disorder/A-D/HD: ____
   ____
7. Other (please list): ____
   ____

<u>REVIEW OF SYMPTOMS:</u>

***MOOD** - Part I*

The following is a list of questions about things you may be experiencing:

1. Do you have history of depression or are you currently feeling depressed? ___Yes ___No

2. If yes, does your depression come and go? ___Yes ___No

If **yes**, how many times has it done so? ____________________________

If **no**, has it been there continuously most of your life? ___Yes ___No

3. How old were you when you were first depressed? ________________________

4. Does the depression get worse in the winter? ___Yes ___No

5. If you are **female**, is your depression (or anxiety/irritability) worse before your periods? ___Yes ___No

6. If you are **female**, are you going through menopause? ___Yes ___No

If **yes**, has your depression gotten worse in the midst of this change? ___Yes ___No

7. Please check the symptoms of depression that you are **<u>currently</u>** experiencing: *PHQ-9

___Little interest or pleasure in doing things*
___Trouble sleeping (too much/little)*
___Loss of appetite/overeating*
___Moving slowly*
___Thoughts of wanting to die*
___Excessive guilt
___Depressed mood*
___Little or no energy*
___Feeling worthless (bad about self)*
___Feeling agitated or stirred-up*
___Irritability
___Withdrawing from others
___Hopeless feeling*
___Low motivation
___Poor concentration*
___Memory impaired
___Recent weight loss

MOOD:

Part II[*MDQ]

Has there ever been a period of time when you were not your usual self and…(Check all that apply)*

___Felt extremely good or hyper
___Shouted at people or started arguments
___Felt incredibly self-confident
___Got much less sleep and didn't miss it
___Couldn't slow your mind down
___Did things others thought were excessive, foolish or risky
___Felt sudden changes in mood
___Had trouble sitting still
___Hard time getting to sleep
___Had trouble concentrating
___Had much more energy
___Were much more active or did more things
___Spent more money than you could afford
___Talking more loudly or faster than usual
___Felt driven to do fun things
___Felt more irritable and angry

If you checked more than one of the above, have several of these ever happened during the same period of time?*
___Yes ___No

How much of a problem did any of these cause you (like being unable to work; having family, money or legal troubles; getting into arguments or fights)?*___No problems___Minor problem ___Moderate problem ___Serious problem

ANXIETY:

Please check all of the following that apply:

___Frequent nervousness or anxiousness
___Frequent worry about a number of things
___Anxious or uncomfortable about being in a social setting
___Muscle/tension pain
___Upset stomach
___Pictures in your mind that play over and over
___Being especially afraid of certain things. Specify: ______________________________________
___Feeling driven to do certain things over and over to feel less nervous? Specify: __________________

Have you had a sudden attack of intense fear or discomfort that included: (Check all that apply)

___Pounding/racing heart
___Sweating
___Trembling/shaking
___Feel like you're losing control
___Trouble breathing
___Chest pain/discomfort
___Sick to your stomach
___Feeling like things are not real
___Lightheadedness
___Feeling like you're not real
___Feel like you are dying
___Numbness or tingling
___Feeling of choking
___Chills

1. How often do these periods of sudden intense fear or discomfort happen? __________________
2. Do you avoid going places because you are worried you may have an anxiety attack? ___Yes ___No
3. Do you have to force yourself to go places that you would prefer to avoid because of this worry? ___Yes ___No

ATTENTION/CONCENTRATION/MEMORY:

1. Do you have difficulty paying attention and concentrating at work, school, or home? ___Yes ___No
2. Is it hard for you to sit still for more than ½ hour at a time? ___Yes ___No
   a. If **yes**, have you had these problems since you were a child? ___Yes ___No
   b. If **no,** when did this start? ____
3. Have you ever been diagnosed with Attention Deficit/Hyperactivity Disorder? ___Yes ___No
   a. If **yes,** by whom? ____ When? _____________
   b. If **yes**, were you treated with medication? ___Yes ___No
   c. If **yes**, what medication? ____

4. **Do you have trouble with your memory?** ___Yes ___No
    a. If **yes**, please explain ____
    b. If **yes**, how long have you had trouble? ____________________________________

PERCEPTION AND BELIEFS:

1. Do you hear things others don't hear? ___Yes ___No
2. Do you see things others don't see? ___Yes ___No
3. Do you believe that others are spying on your or are out to get you? ___Yes ___No
4. Do you think that others are talking about you? ___Yes ___No
5. Do you think that someone is putting thoughts into your head? ___Yes ___No
6. Do you believe you have special powers? ___Yes ___No
7. Do you think that you receive special messages through the TV or radio? ___Yes ___No

STRESSFUL LIFE EVENTS AND EXPERIENCES:

If you feel comfortable doing so, please answer the following questions about experiences that you may have had in your childhood. Please skip any questions that you do not feel comfortable answering. *ACES

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often:***
    a. Swear at you, insult you, put you down, or humiliate you? ___Yes ___No
    b. Act in a way that made you afraid that you might be physically hurt? ___Yes ___No
2. Did a parent or other adult in the household **often or very often: ***
    a. Push, grab, slap, or throw something at you? ___Yes ___No
    b. Ever hit you so hard that you had marks or were injured? ___Yes ___No
3. Did an adult or person older than you **ever: ***
    a. Touch or fondle you or have you touch their body in a sexual way? ___Yes ___No
    b. Attempt or actually have oral, anal, or vaginal intercourse with you? ___Yes ___No
4. Did you **often or very often** feel that:*
    a. No one in your family loved you or thought you were important or special? ___Yes ___No
    b. Your family didn't look out for each other, feel close to each other, or support each other? ___Yes ___No
5. Did you **often or very often** feel that: *
    a. You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? ___Yes ___No
    b. Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? ___Yes ___No
6. Were your parents **ever** separated or divorced?* ___Yes ___No
7. Was your mother or stepmother: *
    a. **Often or very often** pushed, grabbed, slapped, or had something thrown at her? ___Yes ___No
    b. **Sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with something hard? ___Yes ___No
    c. **Ever** repeatedly hit at least a few minutes or threatened with a gun or knife? ___Yes ___No
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?* ___Yes ___No
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?* ___Yes ___No
10. Did a household member go to prison?* ___Yes ___No

If you have had any significant, stressful or traumatic experiences, outside of those listed above, please list them below. These could include but are not limited to, being a victim of a crime, a significant loss, witnessing or experiencing any traumatic event, or physical or sexual abuse/assault/ rape as an adult.

____
____
____
____

Have you had any of these problems **in the past month,** in response to the above noted stressful life experiences?[*PCL]

1. Repeated disturbing memories, thoughts, or images of the stressful experience? ___Yes ___No
2. Repeated, disturbing dreams of the stressful experience? ___Yes ___No
3. Suddenly acting or feeling as if the stressful experience were happening again (as if you were reliving it)? ___Yes ___No
4. Feeling very upset when something reminded you of the stressful experience? ___Yes ___No
5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating), when something reminded you of the stressful experience? ___Yes ___No
6. Avoiding thinking about or talking about the stressful experience or avoiding having feelings related to it? ___Yes ___No
7. Avoiding activities or situations because they remind you of the stressful experience? ___Yes ___No
8. Trouble remembering important parts of the stressful experience? ___Yes ___No
9. Loss of interest in activities that you used to enjoy? ___Yes ___No
10. Feeling distant or cut off from other people? ___Yes ___No
11. Feeling emotionally numb or being unable to have loving feelings for those close to you? ___Yes ___No
12. Feeling as if your future will somehow be cut short? ___Yes ___No
13. Trouble falling asleep or staying asleep? ___Yes ___No
14. Feeling irritable or having angry outbursts? ___Yes ___No
15. Being “super alert” or watchful or on guard? ___Yes ___No
16. Feeling jumpy or easily startled? ___Yes ___No

WEIGHT AND EATING CONCERNS: [*SCOFF]

1. Do you make yourself sick because you feel uncomfortably full? * ___Yes ___No
2. Do you worry that you have lost control over how much you eat?* ___Yes ___ No
3. Do you believe yourself to be fat when others say you are too thin?* ___Yes ___No
4. Have you recently lost more than fourteen pounds in a three month period?* ___Yes ___No
5. Would you say that food dominates your life?* ___Yes ___No

OTHER CONCERNS:

1. Do you experience outbursts of anger? ___Yes ___No
    a. If **yes**, how often: ____daily ____weekly ____monthly ____occasionally
2. At times, do you yell, shout or name call? ___Yes ___No
3. Have you ever been physically violent? ___Yes ___No
4. Do you have any concerns regarding your gender or sexual identity? ___Yes ___No
5. Are you happy/comfortable with your sex life? ___Yes ___No
6. Any difficulties with sexual performance? ___Yes ___No
7. Do you engage in any sexual behavior that concerns you? ___Yes ___No

INTERESTS, STRENGTHS AND ABILITIES:

- **Hobbies and Leisure activities:** Please list any hobbies and leisure activities you enjoy:
- List **strengths and abilities** that you have, that make you who you are:

ADDITIONAL COMMENTS: