**Marion County Behavioral Health-Health History**

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| --- | --- | --- | --- |
|  |  |  |  |
| Client Name | RT# | Date of Birth | Age |

|  |
| --- |
| **Who is your primary care provider?** Name: |

|  |  |  |
| --- | --- | --- |
| Address: | Phone: | Last Visit: |

|  |
| --- |
| **Do you exercise? If so, what type and how often?** |

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| --- |
| **What do you do to relax?** |

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| --- |
| **Do you use tobacco? If so, how much?** |

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| --- |
| **Do you use alcohol or drugs? If so, how much/how often?** |

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| **List any surgeries you have had:** |
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| --- |
| **Do you have any allergies to medications?** ­­­­­­­­­­­­­­­ |

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| **Is there anything else you would like to add?** |
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|  |

**Symtoms that you are currently experiencing:**

Easily distracted  Bingeing or purging  Sexual problems

Difficulty focusing  Feeling nervous/anxious  Lack of motivation

Trouble concentrating  Feeling fearful  Excessive energy  Gambling problems  Feelings of panic  Thoughts of hurting/killing yourself

Sadness  Loss of pleasure/interest  Cutting/self-harm behaviors

Sleep Problems  Feeling Hopeless  Lack of energy/fatigue

Seasonal mood changes  Obsessing  Compulsive spending  Nightmares  Feelings of extreme happiness  Racing thoughts

Flashbacks  Seeing things or hearing voices  Alcohol or drug problems

Eating problems  Suspicion or paranoia

**Are your problems affecting any of the following?**

Handling everyday tasks  Work or school  Living situation

Recreational activities  Legal matters  Relationships

Finances  Health

(Feel free to use the other side of this form if more room is needed)

**History of other Mental Health Providers:**

Issue: Whom did you see? When?

|  |  |  |
| --- | --- | --- |
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|  |  |  |

(Feel free to use the other side of this form if more room is needed)

**Has anyone in your family been treated for mental health concerns?**

Issue: Relationship to you:

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |

**Please list any medications you have taken in the past to help you with your mental health concerns:**

Medication Dose Purpose Stopped because

|  |  |  |  |
| --- | --- | --- | --- |
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**Please list any medications you are taking now (include prescription and over-the-counter meds, herbals, supplements, for both medical and mental health reasons):**

Medication Dose Purpose Who prescribed/recommended?

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| --- | --- | --- | --- |
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**Medical History (check if yes):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Personal History? Dates:  From To | | Family History? | Relationship to You |
| Thyroid Disease |  |  |  |  |
| Liver Disease |  |  |  |  |
| Head Trauma |  |  | NA | NA |
| Seizures or Epilepsy |  |  |  |  |
| Stroke |  |  |  |  |
| Heart Disease/Attack |  |  |  |  |
| Obesity |  |  |  |  |
| High cholesterol/lipids |  |  |  |  |
| High Blood Pressure |  |  |  |  |
| Stomach Problems |  |  |  |  |
| Asthma |  |  |  |  |
| Lung Problems |  |  |  |  |
| Kidney Disease |  |  |  |  |
| Cancer |  |  |  |  |
| Pain |  |  |  |  |
| Diabetes |  |  |  |  |
| Anemia |  |  |  |  |
| LMP (women) |  |  | NA | NA |
| Hearing or Vision problems |  |  |  |  |
| Headaches |  |  |  |  |
| Other Illnesses? |  |  |  |  |

**Developmental History (check if yes):**

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Received Prenatal Care |  |  |
| Birth Complications |  |  |
| Recurring infections |  |  |
| Scabies/Lice/Rashes |  |  |
| In-utero Exposure to Alcohol/Drugs |  |  |
| Developmental targets on time |  |  |
|  |  |  |
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Your Signature Date

**Consent For Treatment**

I have read and/or had the following explained to me as part of my orientation to services with Marion County Health & Human Services (initial those that apply):

Rights and Responsibilities

Complaint and Grievance Procedure

Welcome Letter

Information about a Declaration for Mental Health Treatment (adults)

I give Marion County Health and Human Services permission to provide me with evaluation and treatment services.

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Signature (Individual or Guardian) Date

|  |
| --- |
|  |
| Individual’s Printed Name |

|  |  |
| --- | --- |
| Refused to Sign | Not Able to Sign |
| Circumstances for refusal/inability to sign: | |

# Marion County Health & Human Services

## NOTICE OF PRIVACY PRACTICES

### **Acknowledgement of Receipt**

#### 

**PLEASE REVIEW THIS ACKNOWLEDGEMENT CAREFULLY AND THEN SIGN AND DATE BELOW.**

The Notice of Privacy Practices tells you how the Marion County Health Department may collect, use or disclose health information about you and tells you about your privacy rights. The Health Department is required to offer you a Notice of Privacy Practices by federal law.

|  |
| --- |
| **I,** |
| **Client’s Printed Name** |

have been offered a copy of the Marion County Health Department’s Notice of Privacy Practices and have had a chance to ask questions about how my health information will be collected, used and disclosed and how to access my privacy rights.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client’s Signature Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal or Personal Representative of Client (if applicable) Relationship**

This document is available in other languages and alternate formats that meet the

guidelines for the Americans with Disabilities Act (ADA).

Contact your Service Provider, or call the general number for the Health Department at: Phone# 503-588-5357, or Fax# 503-364-6552.

Health Department Staff: Please have this document completed and signed by the individual receiving the Notice of Privacy Practices.

## Marion County Health & Human Services

## FEE AGREEMENT

I understand that the established fee for services at Marion County Health & Human Services includes office visits, client telephone contacts, and professional consultations on the client’s behalf and is based on my income and the number of dependents in my family. The established fee for services is 0 percent of the full fee for service charge.

I understand and agree to make payment directly to the Marion County Health & Human Services Program for any fees or co-pays due. I understand that if I do not follow this agreement, the Marion County Health & Human Services reserves the right to deny service.

I agree to pay the following pro-rated fees for services per hour as follows:

Assessment  Group  Individual/Family

|  |  |
| --- | --- |
| Client’s Name: |  |

Signature of Client/Individual/Guardian

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Date

**Note:** Consumers with Medicaid funding will not be charged for services and will not be responsible to pay for missed appointments.

### *FEE REDUCED OR WAIVED DUE TO INABILITY TO PAY*

Fee Reduction to \_\_\_\_\_\_\_\_\_\_\_% of the full fee for service charge

Fee Waiver

|  |
| --- |
| Comments: |
|  |
|  |

Supervisor Approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand and agree to the conditions listed above regarding the fee reduction or waiver.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian