Contact Info

Today's Date:

Consumer Name: _____ Address: _____

Birth Name/Other Names: _____ _____

Phone #: _____

Treatment Team Information

Please identify members of this consumer's treatment team:

	Name	Agency	Phone
Psychiatrist:			
Therapist:			
Clinician:			
Service Coord:			
Other:			

Mental Health History

List Psychiatric hospitalizations over the last three years, starting with the most recent:

Hospital	From	To

What is this consumer's usual decompensation pattern?

_____

_____

_____

_____

Medical/Physical Health History

What physical health problems, if any, does this consumer have? _____

_____

Medications

What, if any, are this consumer's current prescription medications? You may also attach an updated list of medications.

NAME	DOSAGE	FREQUENCY	NAME	DOSAGE	FREQUENCY

Is this consumer compliant with his/her current prescription medications? Yes _____ No _____

If not, please describe: _____

_____

Substance Abuse

Date of onset of abuse problem: _____

Please list known substances of choice:

_____

If this consumer is not currently abusing substances, please indicate date of last known use: _____

Is this consumer actively involved in AA? _____ NA? _____

Comments regarding past D/A treatment or rehab:

_____

_____

Housing

What is this consumer's current living arrangement?

____ Independent Living ____ Facility-Based 24-Hour Care ____ Criminal Detention

____Supervised or Supported Living ____ No Permanent Home/Homeless ____ Other

If not independent living, please provide the following information:

Facility Name: _____

Staff Contact: _____

Phone Number: _____

Behavioral

If this consumer is on probation or parole, please provide information:

	Name of Officer	Probation/Parole Agency	Phone
Probation:			
Parole:			

If this consumer is currently facing legal charges, please describe:

_____

_____

Vocational

OVR Counselor: _____ Phone #: _____

Is this consumer able to read and write at the adult level? Yes _____ No _____

How does this consumer's disability interfere with his/her ability to work?

_____

_____

_____

Financial Information

Please list this consumer's monthly income by source:

Salary/Wages _____	SSDI _____	VA Benefits _____
Social Security _____	Pension _____	Other _____
SSI _____	Food Stamps _____	
Domiciliary Care _____	Public Assistance _____	

Describe any financial problems this consumer may be facing:

_____

_____