CentraCare™
St. Cloud Hospital

Patient Identification Label

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. Please fill out as much information as you can; however, if the information is too overwhelming or too triggering, feel free to skip that question or section.

Date Completed: _____ **Referred By:** _____

BASIC INFORMATION:

Name (First, MI, Last) _____ 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 okay 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 ___ 4-12 mo 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

SUBSTANCE USE AND ADDITIVE BEHAVIORS: *CAGE-AID

1. Have you ever felt you ought to cut down on your drinking or drug use?* ___ Yes ___ No
2. Have people annoyed you by criticizing your drinking or drug use?* ___ Yes ___ No
3. Have you ever felt bad or guilty about Your drinking or drug use?* ___ Yes ___ No
4. 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
5. 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? _____
6. 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? _____
7. 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
8. Have you ever misused prescription medications? (e.g. pain pills or anxiety pills) ___ Yes ___ No
   a. If **yes**, what have you used and when?_____
9. 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? _____
10. Has alcohol or drug use caused any problems in the past? ___ Yes ___ No
    a. If **yes**, what kind of problems? _____
11. 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: _____
12. Do you consume caffeinated beverages? ___ Yes ___ No
    a. If **yes**, what beverage, how much, and how often? _____
13. 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
14. 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
15. Do you spend an excessive amount of time on the internet, so much so that it distracts from your ability to complete daily required tasks (i.e., self-care, work, childcare, sleep)? ___ Yes ___ No
    a. If **yes**, how often? ____ Weekly ____ Monthly ____ Occasionally

CURRENT LIFE SITUATION:

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
   - **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	Child lives with me: No	If "No", who does he/she live with and where?

   - **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 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.** How would you describe your childhood? _____
     _____
   - **b.** Were your parents separated or divorced? ___ Yes ___ No
     - **i.** If **yes**, how old were you when that occurred? _____
     - **ii.** Describe the relationship between your parents (check all that apply):
       ____ Healthy ____ Loving ____ Supportive ____Neutral ____ Distant
       ____ Conflicted ____ Abusive ____ Other: _____
   - **c.** What is <u>your</u> relationship with your parents like?
     ____ Healthy ____ Loving ____ Supportive ____Neutral ____ Distant
     ____ Conflicted ____ Abusive ____ Other: _____
     - **i.** Explain: _____
   - **d.** Do you have any siblings? ___ Yes ___ No
     - **i.** If **yes**, how many brothers? _____ How many sisters? _____
       1) Your place in birth order: _____
   - **e.** What is your relationship with your siblings like?
     ____ Healthy ____ Loving ____ Supportive ____Neutral ____ Distant
     ____ Conflicted ____ Abusive ____ Other: _____
     - **i.** Explain: _____
   - **f.** 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 Relationships: _____ 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-wo, 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
   - **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 Provider: _____
2. Primary Care Clinic: _____ City: _____
3. Psychiatric (Mental Health Medication) Provider and Location: _____

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

Conditions

5. General Health – Please respond to each question or statement by marking one box per row: *PROMIS v1.2

In general, would you say your health is:						Excellent	Very Good	Good	Fair	Poor
In general, would you say your quality of life is:						Excellent	Very Good	Good	Fair	Poor
In general, how would you rate your physical health:						Excellent	Very Good	Good	Fair	Poor
In general, how would you rate your mental health, including your mood and ability to think:						Excellent	Very Good	Good	Fair	Poor
In general, how would you rate your satisfaction with your social activities and relationships:						Excellent	Very Good	Good	Fair	Poor
In general, please rate how well you carry out your social activities and roles (activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend)						Excellent	Very Good	Good	Fair	Poor
To what extent are you able to carry out your everyday activities such as walking, climbing stairs, carrying groceries or moving a chair?						Excellent	Very Good	Good	Fair	Poor
In the last 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?						Excellent	Very Good	Good	Fair	Poor
In the last 7 days, how would you rate your fatigue on average?						Excellent	Very Good	Good	Fair	Poor
In the last past 7 days, how would you rate your pain on average?	0 No pain	1	2	3	4	5	6	7	8	9	10 Worst pain imaginable

6. 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? ___ Yes ___ No
     - **i.** If **yes**, list how many and what caused them: _____
       1) Did you receive medical treatment after? ___ Yes ___ No

7. 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: _____

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

Medication	Purpose

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

Allergy to What?	Type of Reaction

10. Are there any <u>medical</u> conditions in your immediate family (including biological family, as well as 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. Is your depression (or anxiety/irritability) worse before your periods? ___ Yes ___ No ___N/A

6. Are you going through menopause? ___ Yes ___ No ___ N/A
   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* ___ Depressed mood* ___ Hopeless feeling*
___ Trouble sleeping (too much/little)* ___ Little or no energy* ___ Low motivation
___ Loss of appetite/overeating* ___ Feeling worthless (bad about self)* ___ Poor concentration*
___ Moving slowly* ___ Feeling agitated or stirred-up* ___ Memory impaired
___ Thoughts of wanting to die* ___ Irritability ___ Recent weight loss
___ Excessive guilt ___ Withdrawing from others

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

___ Felt extremely good or hyper ___ Had trouble concentrating
___ Shouted at people or started arguments ___ Had much more energy
___ Felt incredibly self-confident ___ Were much more active or did more things
___ Got much less sleep and didn't miss it ___ Spent more money than you could afford
___ Couldn't slow your mind down ___ Talking more loudly or faster than usual
___ Did things others thought were excessive, foolish or risky ___ Felt driven to do fun things
___ Felt sudden changes in mood ___ Felt more irritable and angry
___ Had trouble sitting still
___ Hard time getting to sleep

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 problem ___ 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 ___ Chest pain/discomfort ___ Feel like you are dying
___ Sweating ___ Sick to your stomach ___ Numbness or tingling
___ Trembling/shaking ___ Feeling like things are not real ___ Feeling of choking
___ Feel like you're losing control ___ Lightheadedness ___ Chills
___ Trouble breathing ___ Feeling like you're not real

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

***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 you 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

***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? _____

***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 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. Having trouble concentrating? ___ Yes ___ No
16. Being "super alert" or watchful or on guard? ___ Yes ___ No
17. 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 questions or concerns about your gender or sexual identity? ___ Yes ___ No
5. Do you have any concerns about 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

Comments: _____

_____

_____

***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*:**