

# Wabash County Health Department Behavioral Health

## Pre-Assessment/Application

*In order for us to serve you better, please tell us about yourself by completing these questions.*

Social Security Number: \_\_\_\_\_

Name:

First

Middle Initial

Last

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: Male/Female U.S. Citizen? Yes/No

Address:

Street

City

Zip Code

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Race: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Primary Language/Form of Communication: \_\_\_\_\_

Race: \_\_\_\_\_

Do you need an interpreter? Yes/No If yes, please describe: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Education (highest level): \_\_\_\_\_

Do you receive SSI or SSDI? Yes/No Military? Yes/No Veteran? Yes/No

Do you have Medicaid? Yes/No Do you have health insurance? Yes/No

Mother's Maiden Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Referred by: \_\_\_\_\_ Court Ordered: Yes/No

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy : \_\_\_\_\_ Phone: \_\_\_\_\_

How many people do you live with? \_\_\_\_\_ What is your monthly income? \_\_\_\_\_

What is your household monthly income? \_\_\_\_\_

Please describe your reasons for seeking services at this agency: \_\_\_\_\_

Have you ever received outpatient mental health services? Yes/No

If yes, when? \_\_\_\_\_

Where? \_\_\_\_\_

Preassessment 10/10

Page 1 of 5

Have you ever been treated by a Psychiatrist? Yes/No

If yes, when? \_\_\_\_\_

Where? \_\_\_\_\_

What was the date of your most current psychiatric evaluation? \_\_\_\_\_

Are you considering suicide? Yes/No If yes, please explain:  
Have you had any suicide attempts in the past? Yes/No If yes, When:  
Have you ever been hospitalized for Mental Health reasons? Yes/No  
If yes, When? \_\_\_\_\_  
Where? \_\_\_\_\_

What Medications are you currently taking for your Mental Health? \_\_\_\_\_  
\_\_\_\_\_

What Medications have you taken in the past for your Mental Health? \_\_\_\_\_  
\_\_\_\_\_

Has anyone in your family been treated for Mental Health issues? If so, who? \_\_\_\_\_  
\_\_\_\_\_

Do you currently use Alcohol? Yes/No  
If yes, how much and how often? \_\_\_\_\_  
\_\_\_\_\_

Have you ever received treatment for Alcohol dependence or addiction? Yes/ No  
If yes, when and where? \_\_\_\_\_  
\_\_\_\_\_

Do you currently use illegal drugs or abuse prescription medication? Yes/No  
If yes, please describe when and how often: \_\_\_\_\_  
\_\_\_\_\_

Have you ever received treatment for illegal drugs or drug abuse? Yes/No  
If yes, when and where? \_\_\_\_\_  
\_\_\_\_\_

Has anyone in your family had problems with drugs or abuse of prescription medications? Yes/No  
If yes, who and to what extent? \_\_\_\_\_  
\_\_\_\_\_

Do you currently smoke tobacco or use other tobacco products? Yes/ No  
If yes, how many packs per day? \_\_\_\_\_  
\_\_\_\_\_

What was your highest level of education you completed? \_\_\_\_\_

Are you currently enrolled in school? Yes/No  
If yes, where? \_\_\_\_\_  
\_\_\_\_\_

Are you currently employed? Yes/No  
If yes, where and for how long? \_\_\_\_\_  
\_\_\_\_\_

Please describe your work history and special skills you may have: \_\_\_\_\_  
\_\_\_\_\_

Have you ever been in the military? Yes/No  
If yes, when and where did you serve? \_\_\_\_\_  
\_\_\_\_\_

Are you your own guardian? Yes/ No  
If no, please provide the name of your guardian: \_\_\_\_\_  
Guardian phone number/address: \_\_\_\_\_  
\_\_\_\_\_

Any current or pending legal issues? Yes/No  
If Yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Does anyone in your family have any legal problems? Yes/No  
If yes, who and what? \_\_\_\_\_  
\_\_\_\_\_

Who is your Primary Care Doctor? \_\_\_\_\_ Phone number: \_\_\_\_\_

What is the date of your last physical exam? \_\_\_\_\_

Have you gained or lost weight over the past 4 months? Yes/No

If yes, why? \_\_\_\_\_

Are you currently being treated for any medical conditions? Yes/No

If yes, please describe: \_\_\_\_\_

Have you gained or lost more than 10 pounds in the last month? Yes/No

Do you currently have an illness/disorder that causes chronic pain? Yes/No

Are you currently receiving treatment for chronic pain? Yes/No

If yes, please describe: \_\_\_\_\_

Do you have any allergies? Yes/No If yes, please describe: \_\_\_\_\_

Are you currently taking any medications for your physical health? Yes/No

If yes, please describe: \_\_\_\_\_

Have you been in the hospital for any medical condition? Yes/No

If yes, when and for what reason? \_\_\_\_\_

Does anyone In your family have health problems? Yes/No

If yes, who and what kind of problems? \_\_\_\_\_

Do you have children? Yes/No How many? \_\_\_\_\_

Who do you live with? \_\_\_\_\_

Please describe your childhood: \_\_\_\_\_

Do you have any history of family violence, physical or sexual abuse? Yes/No

If Yes, please describe briefly: \_\_\_\_\_

What are your interests or hobbies? \_\_\_\_\_

Do you belong to any religious, cultural, educational, recreational or social groups? Yes/No

If yes, Please describe: \_\_\_\_\_

Are there any cultural or lifestyle issues that you would like us to take into consideration when providing care? Yes/No If yes, please describe: \_\_\_\_\_

Do you feel you have any issues with your sexual development, preference and/or identity? Yes/No

If yes, please describe: \_\_\_\_\_

Please tell us if there is anything else you would like us to know about yourself: \_\_\_\_\_

Client Signature

Date

