Hannahville Behavioral Health | Today's Date: ____________________

Wilson, Michigan | Client # __________________

PERSONAL DATA FORM

The information requested on this form serves two purposes. It allows us to learn many things about you and your background and allows us to gather information we are required to have by our accrediting organization. Thank you for your cooperation and participation. **If you have any difficulties or concerns in filling out this form, please let your clinician know.**

Name: __________________________ Date of Birth: ________________ Age:________ Gender: _________

Address: ____City__________________State_________

Zip Code__________________ Home Phone ____________________ Work Phone ___________________

Race: ☐ Native American ☐ White ☐ Black ☐ Asian ☐ Other: Describe: ______________________________

Please tell us why you are here…

____

____

Family:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Living Together

Household Members:

Name	Relationship
________________________________	______________________________
________________________________	______________________________
________________________________	______________________________
________________________________	______________________________
________________________________	______________________________
________________________________	______________________________

Significant people not living with you: ____

Family History:

Family history of substance abuse: ____

Family history of mental health problems: ____

Family history of incarceration: ____

Family history of completed suicide: ____

List significant losses and traumatic incidents: ____

Medical Information:

Primary Care Physician: ____

Current medical conditions: ____

Are you pregnant? ? Yes ? No

Past medical conditions/surgery: ____

Have you been tested for HIV? ? Yes ? No Do you want an HIV test? ? Yes ? No

P**lease indicate any previous treatment you have received for mental health or substance abuse problems**:

Approximate Dates	Type of Treatment	Institution/Provider	Problem for which you sought help	How helpful was your care?

Have you or are you receiving services from a Traditional Healer? ? Yes ? No
If no, are you interested in Traditional Healing services? ? Yes ? No
Provide the name and dosage of *current prescription medications* you use: NONE ?

Medications	Dosage (including frequency/when used)	Used for What Condition?

Other prescriptions used in the past 2 years: ____

Please provide the names of all over-the-counter, herbals, and/or supplements that you currently use. ? **None**

Social History:

Recreation/leisure activities:
? Volunteer ? Bars ? Stay home ? TV/Movies ? Hobbies ? Dancing ? Classes ? Listen to music ? Casinos
? Sports/Exercise ? Powwows Other ____
Socialize with**:** ? family ? friends ? co-workers ? acquaintances from groups or organizations
Enough support from family/friends: ? Yes ? No

Sexual orientation:

[?] Heterosexual [?] Bisexual [?] Gay [?] Lesbian [?] Transgender [?] Other

Living situation:

[?] Rent [?] Own [?] Living w/ someone [?] Homeless

Employment:

[?] Working full-time [?] Laid off [?] Disabled [?] Homemaker [?] Retired

[?] Working part-time [?] Unemployed

Financial source of income:

[?] Work [?] Significant Other [?] Unemployment [?] Disability [?] Other

[?] Social Security [?] Per Cap

Financial stress: [?] Yes or [?] No

Military history: [?] Yes or [?] No

Legal:

Legal History: Do you have a history of legal problems other than minor traffic violations? ☐ No ☐ Yes
If yes, please answer the following:

Currently on probation or parole? ☐ No ☐ Yes
If yes, name of probation officer ____

Past legal offenses: ☐ No ☐ Yes
If yes, please describe nature/date of offenses: ____________________________________

Traumatic incidents:

Do you have a history of physical abuse? ☐ Yes ☐ No Witnessed domestic violence: ☐ Yes ☐ No

Do you have a history of sexual abuse? ☐ Yes ☐ No Emotional abuse: ☐ Yes ☐ No
Any past attempts at suicide? Self-harm? Please explain: ______________________________

Education:

Education: Highest Grade Completed: __________ What kind of grades did you get? ______________

Received special education? ☐ Yes ☐ No
Current or future educational plans: ____

Spiritual:

Do you practice religion or spirituality? ☐ Yes ☐ No Please describe____________________________

Degree of importance of religion/spirituality in your life *(check the appropriate category below):*

☐ Extremely Important ☐ Moderately Important ☐ Minimally Important ☐ Not At All Important

Abuse/Addiction – Chemical & Behavioral

Drug	Age First Used	Age Heaviest Use	Pattern of Heaviest Use	Recent Pattern of Use (Frequency & Amount, etc)
Alcohol				
Cannabis				
Cocaine				
Stimulants (crystal, Speed, amphetamines, etc.)				
Methamphetamine				
Inhalants (gas, paint, glue, etc)				
Hallucinogens (LDS, PCP, mushrooms, etc)				
Opiods (heroin, narcotics, methadone, etc)				
Sedative/Hypnotics (Valium, Phenobarb, etc)				
Tobacco				
Ever injected Drugs? ? Yes ? No			**If Yes, Which ones?**	
Drug of Choice?				

Consequences as a Result of Drug/Alcohol Use (select all that apply)

? Hangovers ? DTs/Shakes ? Blackouts ? Binges

? Overdoses ? Increased Tolerance ? GI Bleeding ? Liver Disease

? Sleep Problems ? Seizures ? Relationship Problems ? Left School

? Lost Job ? DUIs ? Assaults ? Arrests

? Incarcerations ? Homicide ?Other:

Longest Period of Sobriety:
____

Triggers to use : ____

Are you interested in Medication Assisted Treatment for Addiction? ? Yes ? No

Have you had any of the following problem gambling behaviors? Select all that apply:	
? Gambled longer than planned ? Lost sleep thinking of gambling ? Borrowed money to gamble ? Been remorseful after gambling ? Other:	? Gambled until last dollar was gone ? Used income or savings to gamble while letting bills go unpaid ? Made repeated, unsuccessful attempts to stop gambling ? Broken the law or considered breaking the law to finance gambling ? Gambled to get money to meet financial obligations

Current Concerns:

Please indicate the reasons for which you are seeking treatment now:

? Depression ? Alcohol Abuse ? Family conflict ? Eating difficulties ? Managing stress ? Stress at work ? Sleep problems ? Thoughts of suicide	? Panic attacks ? Drug abuse ? Past trauma ? Weight problems ? Hearing voices ? Legal problems ? Sexual problems ? Thoughts of harming others	? Excessive worry ? Grief/Loss ? Stealing ? Gambling ? Seeing things ? Fears/Phobias ? Flashbacks	? Parenting assistance/training ? Poor self-confidence/low self-esteem ? Conflicts with employer/co-workers ? Relationship problems/break-up ? Repetitive thoughts/behavior ? Self-assertion difficulties ? Coping with physical problems ? Other:

What are your strengths? What are you good at?

____

____

Are there any family members you want involved in your treatment plan here? ___________________________

REVIEWED BY:

____ ____________________
Client Signature **Date**

____ ____________________
Clinician Signature **Date**