1120 Cedar St. Missoula, MT 59802
Phone: (406) 541-4673 Fax: (406) 327-0042

New Client Application for Services

Client Information:

Legal Name:____Date of Birth: _______________________

Preferred Name:___________________Preferred Pronouns:___________Social Security #: _______________________

Referred By:____Gender:____________________

Client Contact Information:

Address:____

Mobile Phone:_________________________________Email:____

Home Phone:__________________________________Work Phone:____

Preferred Method of Communication: ☐Cell Phone ☐Home Phone ☐Work Phone ☐Email

Please tell us the reason for your visit today(Please circle all that apply):

- Anger Management
- Case Management
- Chemical Dependency
  - Substance Use Treatment
  - ACT/Prime for Life Classes
- Functional Medicine/ Wellness Coaching
- Outpatient Therapy
- Medication Management
- Payee Services
- Peer Support
- Other: ____

Payment Information:

Primary Insurance: ____

Secondary Insurance: ____

Other Insurance: ____

Self Pay: ____

Do you have someone else who pays your bills for you, such as a payee? ☐ Yes ☐ No

If you answered "Yes" to the previous question, please fill out the "**Guarantor/Guardian/Responsible Party for Payment**" section at the top of the next page.

Guarantor/Guardian/Responsible Party for Payment:

□Self □Spouse □Child □Other

Guarantor Name: ____

(Leave blank if guarantor is self)

Address: ____

Date of Birth: ____________________ Email Address: ____________________

Primary Phone: ____________________ Secondary Phone: ____________________

Demographics:

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino □Decline to answer

Race: □White □Asian □Black or African American

□Native Hawaiian or Other Pacific Islander □Decline to answer □Other: ______________

□American Indian or Alaskan Native Tribal Affiliation? Y/N If YES, which Tribe? ________________

Preferred Language: □English □Spanish □Other: _____________

Client Next of Kin: ______________________________ Relation: ____________________

Phone: ____________________ Address: ______________________________

Client's Mother's Maiden Name: ______________________________

Health Care History:

Do you currently have a Case Manager? ☐ Yes ☐ No If Yes, whom? ____________________

Case Manager contact info: ______________________________

Primary Care Provider Name and Date Last Seen: ______________________________

Eye Doctor's Name and Date Last Seen: ______________________________

Dentist Name and Date Last Seen: ______________________________

Pharmacy Name and Date Last Seen: ______________________________

Allergies

Medication Allergies: ______________________________

Food Allergies: ______________________________

Environmental Allergies: ______________________________

Have you experienced any of the following symptoms in the past year?

- A productive cough for more than 3 weeks
- Hemoptysis (coughing up blood)
- Unexplained weight loss
- Fever, Chills, or night sweats for no known reason
- Persistent shortness of breath
- Unexplained fatigue
- Chest Pain

Have you had contact with anyone with active tuberculosis disease in the past year? ☐ Yes ☐ No

Do you have a medical condition or taking medications which suppress your immune system? ☐ Yes ☐ No

Childhood Psychiatric History

Before age 18, did you experience any of the following?
Please check all that Apply

- ADD/ADHD
- Oppositional Defiant
- Conduct Disorder
- Learning Disorder
- Anxiety
- Depression
- Frequent irritability
- Separation Anxiety
- Attachment issues
- Sleep Walking
- Sleep Talking
- Repeating Nightmares
- Night Terrors
- Bed-wetting
- Migraines

Comments:____

____

Mental Health History

Have you previously ever been treated for mental health issues? ☐ Yes ☐ No

When:____________________________________by whom:______________________

Diagnoses:____

Provider for these Diagnoses:____

Any Past Hospitalizations for Mental Health? ☐ Yes ☐ No If Yes, Dates:________________________

Family History of Mental Illness and Substance Abuse:_______________________________________

Adult Psychiatric History

Since the age of 18 have you experienced any of the following?
Please check all that Apply

Mood Problems:
- Depression
- Bipolar Disorder/ Manic Depression
- Mania
- Sleep Problems
- Lack of Motivation
- Self-Harm, Cutting, or Burning
- Suicidal thoughts or Suicide Attempts
- Personality Disorder: __________________

Anxiety Problems:
- Posttraumatic Stress Disorder (PTSD)
- Flashbacks
- General Anxiety
- Panic Attacks
- Social Anxiety or Social Phobia
- Obsessive Compulsive Disorder
- Bulimia, Binge Eating, or Anorexia
- Personality Disorder: __________________

Psychosis Problems:
- Schizophrenia
- Schizoaffective
- Paranoia
- Delusions
- Visual Hallucinations
- Auditory Hallucinations
- Catatonic
- Personality Disorder: __________________

Comments: ____

Substance Use History

Substance Use	Current Use	Last Use	Period of Highest Use	Age of First Use	History of Abuse?	Treatment Received?
Alcohol	_____dr/d				Y N	Y N If yes, age:
Caffeine	Y N				Y N	Y N If yes, age:
Nicotine	Y N				Y N	Y N If yes, age:
Marijuana	Y N				Y N	Y N If yes, age:
Amphetamine	Y N				Y N	Y N If yes, age:
Cocaine	Y N				Y N	Y N If yes, age:
PCP	Y N				Y N	Y N If yes, age:
LSD	Y N				Y N	Y N If yes, age:
Opiates	Y N				Y N	Y N If yes, age:
Other	Y N				Y N	Y N If yes, age:

Are you currently pregnant? ☐ Yes ☐ No

If YES, have you used any of the above substances at any point during the duration of the pregnancy? ☐ Yes ☐ No If Yes, please describe:

Have you ever been diagnosed with any of the following?

- HIV/ AIDS
- Hepatitis C
- Tuberculosis (TB)

Past Surgical History

Please list all surgical procedures and radiology procedures you've had and what year they were performed: ____________

____

____

Do you currently exercise? ☐ Yes ☐ No How often? ____

What type of exercise do you do? (I.e. cardio, weight training, etc)_______________________________________

Do you use a seatbelt? ☐ Yes ☐ No

Please supply dates for all of the following that you've had done:

Colonoscopy:___________Mammogram:__________PapSmear:_____________Prostate Exam:_________________

Please list any other Doctors that you currently see:____

____

Family Medical History

Father:

Alive: ☐ Yes ☐ No Current Age:__________Age at Death:_________Cause of death: ____________________________

My father's general health is: □Excellent □Good □Fair □Poor

Health issues: ____

Mother:

Alive: ☐ Yes ☐ No Current Age:__________Age at Death:_________Cause of death: _____________________

My father's general health is: □Excellent □Good □Fair □Poor

Health issues: ____

Siblings:

Number of brothers:__________Number of sisters:____________Age range:____

Health problems:____

Family History of Diseases

Have you or your blood relatives had any of the following (include grandparents, aunts and uncles, but exclude cousins, relatives by marriage and half-relatives)?

- Heart attacks under age 50
- Strokes under age 50
- High blood pressure
- Elevated cholesterol
- Diabetes
- Asthma or hay fever
- Congenital heart disease (existing at birth but not hereditary)
- Heart operations
- Glaucoma
- Obesity (20 or more pounds overweight)
- Leukemia or cancer under age 60

Comments:____

____

Past Medical History

(Check all that apply)

General

- Fever
- Chills
- Night sweats
- Fatigue
- Weakness
- Just don't feel well
- Weight loss
- Sleep problems

Eyes

- Blurring of your vision
- Double vision
- Discharge of the eyes
- Vision loss or change
- Eye pain
- Eyes are sensitive to light

Ears, nose & throat

- Ear ache
- Ear discharge
- Tinnitus/ ringing in ears
- Decreased hearing
- Nasal congestion
- Hoarseness

Cardiovascular

- Chest pains
- Palpitations/ skipped beats
- Syncope/ fainting
- Difficult breathing on exertion
- Difficult breathing laying down
- Swelling in legs or ankles

Dermatology

- Rash
- Itching
- Dryness
- Suspicious skin lesions

Gastroenterology

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Change in bowel habits
- Abdominal pain
- Black, soft tar-like stools
- Bloody stools
- Gas/ bloating
- Indigestion/ heartburn
- Difficulty swallowing
- Decreased appetite

Genitourinary

- Vaginal discharge
- Leaking urine/ incontinent
- Painful urination
- Blood in urine
- Frequent urination
- Missed periods
- Heavy periods
- Unusual vaginal bleeding
- Pelvic pain
- Genital sores
- Decreased libido

Musculoskeletal

- Back pain
- Joint pain
- Joint swelling
- Muscle cramps
- Muscle weakness
- Stiffness
- Arthritis
- Sciatica/ pain down the legs
- Restless legs
- Leg pain at night

Neurology

- Paralysis
- Unusual sensations
- Seizures
- Tremors
- Vertigo/ dizziness
- Temporary blindness
- Frequent falls
- Frequent headaches
- Difficulty walking

Endocrinology

- Constantly cold
- Constantly hot
- Constantly thirsty
- Constantly hungry
- Weight gain

Respiratory

- Cough
- Difficult breathing at rest
- Excessive sputum/ phlegm
- Wheezing
- Runny nose or post nasal drip

Hematology

- Unusual bruising
- Unusual bleeding
- Enlarged lymph nodes

Immune

- Hives
- Food sensitivity
- Frequent colds (respiratory illness)
- Environmental allergies (pollen, etc.)
- History of the flu
- History of mono
- Other infectious disease

Psychiatric Medications

Generic Name	Brand Name	Dose	Result
ANTIDEPRESSANT'S			
TCA/Tetracyclic			
Amitriptyline	Elavil, Endep		
Imipramine	Tofranil		
Desipramine	Norpramin		
Trimipramine	Surmontil		
Clomipramine	Anafranil		
Maprotilene	Ludiomil		
Doxepin	Sinequan		
Nomifensine	Merital		
Nortriptyline	Pamelor,Aventyl		
Protriptyline	Vivactil		
SSRI			
Fluoxetine	Prozac		
Citalopram	Celexa		
Fluvoxamine	Luvox		
Paroxetine	Paxil		
Paroxetine CR	Paxil CR		
Sertraline	Zoloft		
Escitalopram	Lexapro		
SNRI			
Venlafaxine	Effexor		
Duloxetine	Cymbalta		
Desvenlafaxine	Pristiq		
Other Antidepressants			
Bupropion	Wellbutrin		
Mirtazapine	Remeron		
Nefazodone	Serzone		
Trazodone	Desyrel		
Amozapine	Asendin		
Trintellix	Vortioxetine		
Rexulti	Brexpiprazole		
MAOI			
Phenelzine	Nardil		
Selegiline	Elsepryl		
Selegiline(transdermal patch)	Emsam		
Tranylcypromine	Parnate		
Isocarboxazid	Marplan		
Anti-anxiety Meds.			
Alprazolam	Xanax		
Buspirone	Buspar		
Chlordiazepoxide	Librax,Librium		
Clonazepam	Klonopin		
Clorazepate	Azene, Tranxene		
Diazepam	Valium		
Gabapentin	Neurontin		
Halazepam	Paxipam		
Lorazepam	Ativan		
Oxazepam	Serax		
Prazepam	Centrax		
Pregablin	Lyrica		
Lithium Carbonate	Eskalith,Lithane,Lithobid		
Lithium Citrate	Cibalith-S		
Topimarate	Topamax		

\ **Psychiatric Medications Cont.**

Generic Name	Brand Name	Dose	Result
Sleep Medications			
Eszopiclone	Lunesta		______________
Ramelteon	Rozerem		______________
Zaleplon	Sonata		______________
Zolpidem	Ambien		______________
Zolpidem (sub. Tablet)	Edluar		______________
Zolpidem (oral spray)	Zolpimist		______________
Melatonin			

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Generic Name	Brand Name	Dose	Result
Antipsychotic Medications			
Aripiprazole	Abilify		______________
Chlorpromazine	Thorazine		______________
Chlorprothixene	Taractan		______________
Clozapine	Clozaril		______________
Fluphenazine	Prolixin		______________
Haloperidol	Haldol		______________
Loxapine	Loxitane		______________
Mesoridazine	Serentil		______________
Molindone	Lidone, Moban		______________
Olanzapine	Zyprexa		______________
Perphenazine	Trilafon		______________
Pimozide	Orap		______________
Quetiapine	Seroquel		______________
Risperidone	Risperdal		______________
Thioridazine	Mellaril		______________
Thiothixene	Navane		______________
Trifluoperazine	Stelazine		______________
Trifluopromazine	Vesprin		______________
Ziprasidone	Geodon		______________
Lurasidone	Latuda		______________
Antimanic Medications			
Carbamazepine	Tegretol		______________
Valproic Acid	Depakote		______________
Gabapentin	Neurontin		______________
Lamotrigine	Lamictal		______________

Vitamins/Minerals/Supplements:

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____

____

Other Medications and Dosages:

____

____

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Authorization for Release of Information

Client Name: ____
Last First Middle
(Other Names Used) ____

Date of Birth: _____/_____/_____ SSN: _____/_____/__________ Phone: ____________________

I hereby authorize: ___Winds of Change ____ Release records to ____ Obtain records from

Name: ____
Agency: ____
Address: ____
Phone: ____ Fax: __________________

Please Initial Specific information to be released/obtained:

___ History & Physical____ Intake/Discharge Summary____ Notes: from ______ to _________ (time frame)
____ Labs____ Progress Report/TX Plan____ Medication List____ Consults____ Financial information
____ other (Please describe) __________________________________

___ I understand that this could include information related to AIDS or HIV, Psychiatric or Mental Health Care, or treatment information related to alcohol or drug abuse.

Please specify the reason for disclosure:

____ Changing Providers _____ Legal ____ Continuation of Care ____ School ____ Insurance
_____ other (Please describe) _________________________________

I voluntarily allow the above-named agencies to disclose information to facilitate my treatment. I understand that this information will not be disclosed to anyone other than those participating in my treatment continuum without my written permission. I additionally understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on (i.e. probation or parole, etc.) and that, in any event, this consent (unless expressly revoked) expires as described below:

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Client Signature or Client Representative: ______________________________ Date: ______________
Witness Signature: ____ Date: _________________

This authorization is good for two years from the date signed, unless revoked or specified otherwise.