

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: Home Phone:

Email:

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 Dependencyo Substance Use Treatmento 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:

Yes

No



Do you have someone else who pays your bills for you, such as a payee?

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 Y

es

, 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?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| o o | A productive cough for more than 3 weeksHemoptysis (coughing up blood) | o o | Unexplained weight lossFever, Chills, or night sweats for no known reason | o  o o | 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/ADHDo Depressiono Sleep Talking
* Oppositional Defiant o Frequent irritability o Repeating Nightmares o Conduct Disorder o Separation Anxiety o Night Terrors
* Learning Disordero Attachment issues o Bed-wetting o Anxietyo Sleep Walkingo 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:

Yes

No

If Yes, Dates

:



Any Past Hospitalizations for Mental Health? 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: Anxiety Problems: o Personality Disorder: o Depression o Posttraumatic Stress \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ o Bipolar Disorder/ Manic Disorder (PTSD)

Depression o Flashbacks Psychosis Problems: o Mania o General Anxiety o Schizophrenia

* Sleep Problems o Panic Attacks o Schizoaffective o Lack of Motivation o Social Anxiety or Social o Paranoia
* Self-Harm, Cutting, or Phobia o Delusions

Burning o Obsessive Compulsive o Visual Hallucinations o Suicidal thoughts or Disorder o Auditory Hallucinations Suicide Attempts o Bulimia, Binge Eating, or o Catatonic o Personality Disorder: Anorexia o 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  Have you ever been diagnosed with any of the following?  o HIV/ AIDS o Hepatitis C  **Past Surgical History** | No If Yes, please describe:    o Tuberculosis (TB) |

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

Comments:

General o Fever o Chills o Night sweats o Fatigue o Weakness

* Just don’t feel well o Weight loss o Sleep problems

Eyes o Blurring of your vision o Double vision o Discharge of the eyes o Vision loss or change

* Eye pain
* Eyes are sensitive to light

Ears, nose & throat o Ear ache o Ear discharge o Tinnitus/ ringing in ears o Decreased hearing o Nasal congestion o Hoarseness

Cardiovascular o Chest pains o Palpitations/ skipped beats o Syncope/ fainting o Difficult breathing on exertion

* Difficult breathing laying down
* Swelling in legs or ankles

Dermatology o Rash o Itching

* Dryness o Suspicious skin lesions

# Past Medical History

(Check all that apply)

Gastroenterology o Nausea o Vomiting o Diarrhea o Constipation o Change in bowel habits

* Abdominal pain
* Black, soft tar-like stools o Bloody stools o Gas/ bloating o Indigestion/ heartburn o Difficulty swallowing o Decreased appetite

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

Musculoskeletal o Back pain o Joint pain o Joint swelling o Muscle cramps o Muscle weakness o Stiffness o Arthritis o Sciatica/ pain down the

legs

* Restless legs o Leg pain at night Neurology o Paralysis o Unusual sensations o Seizures o Tremors
* Vertigo/ dizziness o Temporary blindness o Frequent falls o Frequent headaches o Difficulty walking

Endocrinology o Constantly cold o Constantly hot o Constantly thirsty o Constantly hungry o Weight gain

Respiratory

* Cough
* Difficult breathing at rest o Excessive sputum/ phlegm
* Wheezing
* Runny nose or post nasal

drip

Hematology o Unusual bruising o Unusual bleeding o Enlarged lymph nodes

Immune o Hives

* Food sensitivity
* Frequent colds (respiratory illness)
* Environmental allergies

(pollen, etc.) o History of the flu o History of mono o 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  **SSRI** | Vivactil |
| Fluoxetine | Prozac |
| Citalopram | Celexa |
| Fluvoxamine | Luvox |
| Paroxetine | Paxil |
| Paroxetine CR | Paxil CR |
| Sertraline | Zoloft |
| Escitalopram  **SNRI** | Lexapro |
| Venlafaxine | Effexor |
| Duloxetine | Cymbalta |
| Desvenlafaxine  **Other Antidepressants** | Pristiq |
| Bupropion | Wellbutrin |
| Mirtazapine | Remeron |
| Nefazodone | Serzone |
| Trazodone | Desyrel |
| Amozapine | Asendin |
| Trintellix | Vortioxetine |
| Rexulti  **MAOI** | Brexpiprazole |
| Phenelzine | Nardil |
| Selegiline | Elsepryl |
| Selegiline(transdermal patch) | Emsam |
| Tranylcypromine | Parnate |
| Isocarboxazid  **Anti-anxiety Meds**. | Marplan |
| 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

**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

|  |  |  |  |
| --- | --- | --- | --- |
| Lurasidone    **Antimanic Medications**  Carbamazepine |  | Latuda  Tegretol | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Trifluoperazine Stelazine

Trifluopromazine Vesprin

Ziprasidone Geodon

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.

Winds of Change 1120 Cedar St Missoula, MT 59801 PH: 406.541.4673 Fax: 406.327.0042