WINDS OF CHANGE
MENTAL HEALTH CENTER
3000 Palmer St., Ste. B, Missoula, MT 59808
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
  - ☐ Prime for Life/ Act Classes
  - ☐ IOP Treatment
- ☐ Outpatient Therapy
- ☐ Medication Management
- ☐ 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, 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 mother'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			
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:

Other Medications and Dosages:

WINDS OF CHANGE
MENTAL HEALTH CENTER

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.

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Submit