Southwestern Behavioral Healthcare, Inc.

415 Mulberry Street
Evansville, IN 47713

P. 812.423.4700
F. 812.422-7558
www.southwestern.org

EAP ADULT INFORMATION SHEET

Patient Name______________________________ DOB: ____/____/________ Age: ______ M / F (circle one)

What would you like to be called?_____________________________

Please check any problem areas bothering you lately:

- ☐ Job
- ☐ Parenting/Child Problems
- ☐ Divorce/Stepfamily
- ☐ Suicide thoughts/attempts
- ☐ Obsessions/Compulsions
- ☐ Eating/Appetite/Weight/Food Worries
- ☐ Withdrawn/Shy/Few Friends
- ☐ Relationship/Marriage Issues
- ☐ Impulsive
- ☐ Alcohol/Drugs (self)
- ☐ Relatives problems
- ☐ Cutting/Self-injury to feel better
- ☐ Health/Pain/Medication problems
- ☐ Hallucinations
- ☐ Gay/Lesbian/Bi/Transgender issues
- ☐ Finances
- ☐ Violence/Physical Abuse
- ☐ Depression
- ☐ Worries/Anxiety/Panic Attacks
- ☐ Sleep Problems/Tired
- ☐ Self-Esteem
- ☐ Concentration/Focus/Forgetfulness
- ☐ Irritability/Temper/Anger
- ☐ Sexual Abuse/Date Rape
- ☐ Alcohol/Drugs (other)
- ☐ Death of a loved one/Other losses
- ☐ Harm to others
- ☐ Legal Problems
- ☐ Sexual Problems
- ☐ Other____

What are your goals for evaluation/treatment?____

Current Family Information: (please complete with information for those living with you)

Family Member (Names)	Relationship	Mental Health or Substance Abuse Issue	Current Relationship (excellent, fair, etc.)

Development History for Patient:

To the best of your knowledge, were you/did you…

		Additional Comments:
…have learning issues	Yes No	
…have behavioral issues	Yes No	
…have medical issues	Yes No	
…have serious injuries	Yes No	
…a survivor of abuse (physical, emotional, sexual)	Yes No	
…have divorced or separated parents	Yes No	

Education/Work History:
Highest educational level completed:______________

Current Occupation:_________________ Employer:__________________________________

Length of time at current occupation:________________ Satisfaction Level: High / Average / Low *(circle one)*

Current Vocational Problems:____

Are you on disability or applying for disability? Yes / No *(circle one)*

Mental Health History:
Have you EVER: _____Made a suicide attempt_____Hurt yourself on purpose _____Overdosed, on purpose or accident

Have you experienced any type of traumatic event that still bothers you (i.e. serious accident, disaster, victim of crime, death in family, history of physical or sexual assault)? Yes / No *(circle one)*
Please describe:____

Have you ever participated in **inpatient** (overnight) psychiatric treatment? Yes / No *(circle one)*

What mental health conditions were you treated for?____

Where	When	Reason	Length of Stay

Have you ever participated in outpatient (at an office) psychiatric treatment? Yes / No *(circle one)*

What mental health conditions were you treated for?____

Are you currently in mental health treatment with anyone else? Yes / No *(circle one)* If yes, please complete below:

Where	When	Reason	Length of Treatment

Have you ever been prescribed mental health medications before? Yes / No *(circle one)* If yes, please complete below:

Medication	Date	Dose	Reason	Effective	Prescriber	Side Effects
				Yes No		
				Yes No		
				Yes No		

Medical History:
Primary Care Physician:____________________________

Rate your overall health: Excellent Good Poor Very Poor *(circle one)*

List any serious medical conditions, surgeries, head injuries, hospitalizations, or accidents you have had:___________________

____

Do you have a history of diabetes, hypertension, or thyroid problems? Yes / No If yes, which?________________________

Are you currently experiencing chronic or acute pain? If so, describe____

Are you currently in treatment for any medical conditions? Yes / No If yes, please complete below:

Condition	Physician	Medications

Substance Use History:

Do you use any alcohol or drugs? Yes / No

If yes, how many drinks per day_______

Do you smoke cigarettes? Yes / No

If yes, how many per day_______ cigarettes OR packs *(circle one)*

List any negative consequences from substance use (i.e. family problems, work problems, etc.):_________________________

____

Please complete for self:

Substance	Frequency	Age of First Use	Last Used

List any previous substance abuse treatment:

Where	When	Type (inpatient, outpatient, group)	Length of Treatment

Sleep:

To bed at ___________am/pm Up from bed at ____________am/pm

TV/computer/cell phone hours daily_______ Average hours sleep per night last week_______

Hours per night you need to feel rested and alert________

- ☐ Can't get to sleep
- ☐ Wake up frequently
- ☐ Hard to return to sleep
- ☐ Naps *How many per day*______
- ☐ Wake up too early
- ☐ Oversleep
- ☐ Wake up tired
- ☐ Sleep walking
- ☐ Snore/Stop breathing while sleeping
- ☐ Nightmares *How many time per week*_____

Appetite:

- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Healthy/nutritious food
- ☐ Lots of junk food

Caffeine:

Servings per day: _____Coffee ______Caffeinated sodas ______ Power/energy drinks ______Pills

Legal History:

Have you ever been arrested, incarcerated, or on probation? Yes / No

Explain:____

Are you currently on probation or involved with the legal system in any way? Yes / No

If you have a probation officer, please list their name____

Explain:____

Current Functioning:
What are some of your interest and hobbies?____

What are your strengths?____

What are your difficulties?____

What other things about your life would it be important for us to know?____

____

____

Please also provide copies of any documents (i.e. previous evaluations, legal papers, consents, etc.) that would help us get to know you better. We look forward to meeting with you!

The Staff at Southwestern Behavioral Healthcare, Inc.