Public Health
Prevent. Promote. Protect.
Harford County
Health Department

DIVISION OF BEHAVIORAL HEALTH
REGISTRATION FORM

Today's Date:

CLIENT INFORMATION **PATAGONIA#** _____

Client's Last Name : First: Middle Initial:

Legal Name: Former/Maiden Name(s):

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Birth Date: Is the client a United States Citizen Yes / No

Gender (Please Check):
☐ Male ☐ Female ☐ Declined

Please check: ☐Married ☐Never Married ☐Divorced
☐Separated ☐Widowed

Race: _____ Ethnicity: _____ ☐ Decline to Answer

Does client have a Legal Representative? YES / NO

If yes, complete below: Name of Representative: _____

Relationship: _____ Contact Number: _____

Address: _____

Documented Verification of Legal Representation Received Y / N

If document was not received, explain: _____

Primary Address: _____

Preferred Mailing Address (if different then above): _____

Home phone # ___ ___ ___-___ ___ ___-___ ___ ___ ___ Cell phone#: ___ ___ ___-___ ___ ___-___ ___ ___ ___ Text: Y / N

Email Address: Preferred Method of Contact: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Contact Number: _____ Address: _____

Name: _____ Relationship: _____

Contact Number: _____ Address: _____

DIVISION OF BEHAVIORAL HEALTH
REGISTRATION FORM

Services Requested: Check all that Apply	Referred By:
✡ Mental Health ✡ Addictions ✡ Methadone ✡ Residential ✡ Detox ✡ Suboxone/Vivitrol ✡ Other (Please Specify): Have you received services here before? Yes / No	✡ Friend/Family ✡ Hospital: Name: _____ ✡ Treatment Provider/Other Please Specify:_____

Are you currently enrolled in another drug, alcohol or mental health program, is so please indicate

Name of Program: Type of Service:

What language does client feel most comfortable speaking in with their counselor?

Reasonable accommodations needed (interpreter, etc.)?

Are you a HURRICANE victim? Yes / No

Have you **OVERDOSED** recently? Yes / No When:_____

Priority services:

Are you an IV Drug Users? Yes / No

Have you been diagnosed with HIV or AIDS? Yes / No

Are you Pregnant? Yes / No

INSURANCE INFORMATION **UNINSURED: YES / NO**

Have you or your immediate family member ever served in Military? Yes / No

Do you have health benefits through Veterans Administration (VA)? Yes / No

Referred: Yes / No Referral Number: 800-827-1000

Please indicate primary insurance carrier:		Subscriber's name:
Subscriber's S.S. number: __ __ __ - __ __ - __ __ __ __	Subscriber's Birth date: __ __ / __ __ / __ __ __ __	MA/Policy Number:
Relationship to subscriber:		
Name of secondary insurance carrier (if applicable):		Subscriber's name:
Subscriber's S.S. number: __ __ __ - __ __ - __ __ __ __	Subscriber's Birth date: __ __ / __ __ / __ __ __ __	MA/Policy Number:
Relationship to subscriber:		

History 1

What is the reason for your visit?

When did you last feel really well?

Has your mood been excessively happy or irritable?	Y	N
Have you been experiencing mood swings?	Y	N
Racing thoughts?	Y	N
Increase in activities, projects or planning?	Y	N
Have you been talking more or faster than usual?	Y	N
Have you needed less sleep and not felt tired?	Y	N
If you have been thinking of harming yourself, do you have a specific plan to hurt yourself?	Y	N
If you have been thinking of harming yourself, do you intend to hurt yourself?	Y	N
Have you ever had thoughts of wanting to die or wanting to kill yourself?	Y	N
Have you ever tried to hurt yourself by cutting, burning or banging your head?	Y	N
Have you ever tried to kill yourself?	Y	N
Have you have had thoughts of harming others?	Y	N
Do you have a history of violence toward other people?	Y	N
Do have you have a history of violence to animals or fire setting?	Y	N
Do you experience panic attacks?	Y	N
Are you anxious in social settings (eating or talking in front of people)?	Y	N
Do you feel that you worry more than the average person?	Y	N
Do you have any specific or unusual fears?	Y	N
Do you have obsessive, repetitive or intrusive thoughts?	Y	N
Do you have compulsive, repetitive thoughts/ behaviors (cleaning, counting, checking, sex)?	Y	N
Do you obsessively focus on one part of your body or repeatedly check your appearance?	Y	N
Do you repeatedly pull out your hair or pick your skin?	Y	N
Do you have a difficult time discarding personal items regardless of their worth?	Y	N
Have you experienced any traumatic events in the past (abuse, attacks, or accidents)?	Y	N

If yes, do you have nightmares, intrusive thoughts or flashbacks about these traumatic events?	Y	N
Do you experience any difficulties in your sex life (drive/desire, function)?	Y	N
Have you ever been unsure of or unhappy with your sexual identity or sexual orientation?	Y	N
Recently, have you experienced stress related to your personal relationships?	Y	N
Recently, have you experienced stress related to your work/employment/education?	Y	N
Recently, have you experienced stress related to your housing?	Y	N
Recently, have you experienced stress related to you finances or other issues?	Y	N
Have you ever heard voices or seen visions that others did not see or hear?	Y	N
Do you feel that people are trying to hurt you, follow, you or give you a hard time?	Y	N
Do you feel that people are talking about you?	Y	N
Do you receive messages from the TV or radio that are meant just for you?	Y	N
Do you believe you have special powers or abilities that others do not have?	Y	N
Do you believe that forces outside of your body control you?	Y	N
Do you feel you can read others minds?	Y	N
Do you have problems with your memory?	Y	N
Do you have periods of confusion?	Y	N
Have you ever been excessively fearful of gaining weight?	Y	N
Have you had periods of restricting your food intake to an unhealthy degree in order to lose weight?	Y	N
Have you ever been severely underweight?	Y	N
Have you ever had periods of severe binge eating?	Y	N
Have you had periods of self-induced vomiting, laxative abuse or excessive exercise to lose weight?	Y	N
Have you abused diet pills?	Y	N
Have you ever felt as if you were outside of your body or felt that the world around you was not real?	Y	N
Have you experienced chronic mood swings?	Y	N
Have you experienced chronic anger?	Y	N
Chronic feelings or emptiness	Y	N
Chronic fears of abandonment?	Y	N
Chronic issues with intense interpersonal relationships (abuse, fights, "love-hate")?	Y	N

How old were you when you first experienced psychiatric symptoms (depression, anxiety, etc.)?

How old were you when you first received treatment (medications or therapy)?

Have your symptoms been consistent throughout your life?		
Have you ever taken medications for depression, anxiety, sleep or other psychiatric issues?	Y	N
Have you ever been evaluated by a psychiatrist?	Y	N
Have you ever been treated by a therapist or a counselor?	Y	N
Have you ever been hospitalized for psychiatric issues?	Y	N
Have you ever received electroconvulsive (ECT/shock) therapy?	Y	N
Have you received vagal nerve stimulation (VNS) or transcranial magnetic- stimulation (TMS)?	Y	N
Have you attended a structured outpatient psychiatric or substance abuse treatment program?	Y	N
Have you ever had a significant problem with alcohol?	Y	N
Have you ever had a significant problem with drugs?	Y	N

CIRCLE ALL PAST MEDICATIONS

ANTIDEPRESENTS

CELEXA/ CLTALOPRAM
LEXAPRO/ ESCITALOPRAM
PROZAC/ FLUOXETINE
LUVOX/ FLUVOXAMINE
PAXIL/ PAXIL CR/ PAROXTINE
ZOLOFT/ SERTRALINE
CYMBALTA/ DULOXETINE
EFFEXOR/ VENAFAXINE
PRISTIQ/ DESVENLAFAXINE
WELLBUTRIN/ BUPROPRION
APLENZIN/ ZYBAN/ BUPROPRION
REMERON/ MIRTAZAPINE
OLEPTRO/ TRAZODONE
ELAVIL/ AMITRIPTYLINE
ANAFRANIL/ CLOMLPRAMINE
NORPRAMIN/ DESLPRAMINE
SILENOR/ DOXEPIN
TOFRANIL/ IMIPRAMINE
PAMELOR/ NORTLPTYLINE
MARPLAN/ ISOCARBOXAZID
NARDIL/ PHENEIZINE
ELDEPYL/ ERNSAM/ SELEGELINE
PARNATE/ TRANYLCYPROMINE
VIIRYD/ VILAZODONE
BRINTELLIX/ VOTIOXETINE
FETZIMA/ LEVOMILNACIPRAN

ANTIPSYCHOTICS

VRAYLAR/ CARIPRAZINE
REXULTI/ BREXPIPRAZOLE
ABILLFY/ ARIPIPRAZOLE
SAPHRIS/ ASENAPINE
CLOZARIL/ CLZAPINE
FANAPT/ ILOPERIDONE
LATURDA/ LURASIDONE
ZYPREXA/ OLANZAPINE
INVEGA/ PALIPERIDONE
SEROQUEL/ QUETIAPINE
RISPERDAL/ RISPERIDONE
GEODON/ ZIPRASIDONE
THORAZINE/ CHLORPRORNAZINE
PROLIXIN/ FLUPHENAZINE
HALDOL/HALOPERIDOL
TRILAFON/ PERPHENZINE
ORAP/ PLMOZIDE
MELLARIL/ THIORIDAZINE
NAVANE/ THIOTHIXENE
STELAZINE/ TRIFLUOPERAZINE

LONG-ACTING INJECTIONS

HALDOL DECNOATE
PROLIXIN DECANOATE
RISPERDAL CONSTA
INVEGA SUSTENNA/ TRINZA
ABILIFY MAINTENA/ ARISTADA

BIPOLAR

TEGRETOL/ CARAMAZEPINE
LAMICTAL/ IAMOTRIGINE
LITHOBID/ LITHIUM
TOPAMAX/ TOPIRMATE
DEPAKOTE/ STAVZOR/ VALPROIC ACID
TRILEPTAL/ OXCARBAZEPINE
SYMBYAX

ANXIETY / SLEEP

LIBRIUM/ CHLORDIAZEPOXIDE
KLONOPIN/ CLONZZEPAM
TRANXENE/ CLORAZEPATE
VALIUM/ DIAZEPAM
FALMANE/ FLURAZEPAM
AVTIVAN/ LORAZEPAM
RESTORIL/ TERNAZEPAM
XANAX/ ALPRAZOLAM
SERAX/ OXAZEPAM
HALCION/ TRIAZOLAM
BUSPAR/ BUSPIRONE
CHLORAL HYDRATE
LUNEST/ ESZOPICLONE
ROZEREM/ REMELTEON
SONATA/ ZALEPLON
AMBIEN/ INTERMEZZO/ ZOLPIDEM
EDLUAR/ ZOLPIDEM
XYREM/ SODIUM OXYBATE
VISTARIL/ HYDROXYZINE
OLEPTRO/ TRAZODONE
MELATONIN

STIMULANTS/ ADHD/ Diet

NUVIGIL/ ARMODAFANIL
PROVIGIL/ MODAFANIL
STRATTERA/ ATOMOXETINE
INTUNIV/ GUANFACINE
FOCALIN/ DEXMETHYLPHENIDATE
DEXEDRINE/ DEXTROAMPHETAMINE
ADDERALL/ MIXED AMPHETAMINE
VYVANSE/ LYSDEXAMPHETAMINE
RITALIN/ LA/ METHYLPHENIDATE
MEDADATE CD/ METHYLPHENIDATE
PHENTERMINE
QSYMIA/ PHENTERMINE+TOPIRAMATE

MEMORY/ DEMENTIA

ARICEPT/ DONEPEZIL
RAZADYNE/ GALANTAMINE
EXELON/ RIVASTIGMINE
NAMENDA/ MEMANTINE
NAMZARIC/ MEMANTINE+DONEPEZIL

SUBSTANCE ABUSE

CAMPRAL/ ACAMPROSATE
ANTABUSE/DISULFIRAM
REVIA/ VIVTROL/ NALTREXONE
NICOTINE REPLACEMENT
SUBOXONE/ BUNAVAIL/ ZUBSOLV/ SUBTEX/ BUPRENORPHINE
CHANTIX/ VARENICLINE

PAIN

BELBUCA/ BUPRENORPHINE
EXALGO/ HYRDOMORPHONE
TORADOL/ KETOROLAC
ZIPSOR/ DICLOFENAC
ESGIC/ FIORCET/FIORINAL
SOMA/ CARISOPRODOL
ULTRAM/ ULTRACET/ TRAMADOL
NEURONTIN/ GABAPENTIN
LYRICA/ PREGABALIN
CODEINE
DURAGESIC/ ACTIQ/ FENTANYL
DILAUDID/ HYDROMORPHONE
DEMEROL/ MEPERIDINE
METHADONE
MS CONTIN/ MORPHINE
OXYCOTIN/ OYCODONE
PERCOSET/PERCODAN/ OXYCODONE
XARTEMIS XR/OXYCODONE
DARVON/ PROPOXYPHENE
DARVOSET/ PROPOXYPHENE
LORCET/ ORTAB/HYDROCODONE
NORCO/ VICODIN/ HYDROCODONE
VICOPROFEN/ HYDROCODONE
ZOHYDRO ER/ HYDROCODONE

OTHER

COGENTIN/ BENZTROPINE
ARTANE/TRIHEXYLPHENIDATE
BENADRYL/ DIPHENHYDRAMINE
NALOXONE
INDERAL/ PROPRANODOL
METFORMIN/ GLUCOPHAGE
SYNTHROID/ LEVOTHYROXINE
CYTOMEL/IIOTHYRONINE
PERIACTIN/ CYPROHEPTADINE
EPHERDRA/ GUARANA
GINGKO BILOBA
ST. JOHN'S WORT
YOHIMBINE

If you have used nicotine products (cigarettes, chewing tobacco, etc), at what age did you start using?_____

How much and how frequently do you use nicotine products?_____

At what age did you first drink alcohol?_____

When was your last drink of alcohol?_____

When you do drink alcohol, about how many drinks do you have?_____

During your period of heaviest drinking, how much and how frequently do you drink?_____

Has alcohol caused any problems in your relationships, at work , or caused legal issues?_____

Have you ever had withdrawal symptoms from alcohol, like shaking, seizures, DT's?_____

If you have used, at what age did you first use marijuana?_____

When was the last time you used marijuana? _____

How much and how often do you use marijuana? _____

At your heaviest, how much and how frequently did you use marijuana?

_____

If you have used, at what age did you first use cocaine?_____

When was the last time you used cocaine? _____

How much and how often do you use cocaine? _____

At your heaviest, how much and how frequently did you use cocaine?

_____

If you have used, at what age did you first use heroin or abuse pain killers?_____

When was the last time you used heroin or abused pain medications? _____

How much and how often do you use heroin or pain medications? _____

At your heaviest, how much and how frequently did you use heroin or pain medications?_____

If you have used, at what age did you first use sedatives (Xanax, Valium, Klonopin, etc.) ?_____

When was the last time you used sedatives? _____

How much and how often do you use sedatives? _____

At your heaviest, how much and how frequently did you use sedatives?

_____

If you have used, at what age did you first use other drugs (hallucinogens, spice, inhalants, etc) ?

_____

When was the last time you used other drugs? _____

Have you ever used any drugs intravenously (IV, needles,...) ?_____

Have you ever experienced issues with gambling (trouble stopping, hiding losses, relationship issues)?_____

Have you ever gone to 12 step meetings (AA/NA), a detox facility or a rehab center for treatment?

_____

MEDICAL/ FAMILY

Do you suffer from any significant medical conditions? Y N

If yes, please list them. _____

Have you ever had any surgeries or significant procedures? Y N

If yes, please list them. _____

Do you have any risk factors form HIV or hepatitis (unprotected sex, intravenous drug use, multiple partners)? Y N

Any history of closed head injuries or traumatic brain injuries? Y N

Any history of seizures? Y N

If you are a woman of childbearing age , are you currently using birth control? Y N

Are you having pain now? Y N

If you are having pain, where is that pain located?

_____

If pain, please describe (dull sharp, shooting, burning, etc.)?

_____

Does anyone in your family suffer from significant psychiatric illness or symptoms? Y N

If yes, please list family member and illness.

_____

Does anyone in your family have any history of significant alcohol or substance use? Y N

If yes, please list family members and substance.

_____

Has anyone in your family experienced suicidal thoughts? Y N

If yes, who?

_____

Has anyone in your family attempted suicide? Y N

If yes, who?

_____

Has anyone in your family completed suicide? Y N

If yes, who?

Has anyone in your family had issues with violence or aggression? Y N

If yes, who suffered what illness?

Has anyone in your family suffered from neurological problems like dementia, strokes, seizures, multiple sclerosis? Y N

If yes, who suffered from what illness?

Has anyone in your family suffered from conditions like high blood pressure, cholesterol, heart disease, diabetes, obesity?

Y N

If yes, please list family member and illness.

Social

As far as you know, did your mother have any issues with her pregnancy?

As far as you know, did you have any delay in your early development (walking, talking, etc)

Who raised you?

How many siblings do you have?

How would you describe your childhood?

What is the highest level of education you have completed?

How well did you perform in school (average grades)?

Did you have any significant behavioral issues in school (often in trouble, fights, etc)?

What type of work do you do?

If unemployed, when did you last work?

What type of work have you done in the past?

If not working, how are you supporting yourself?

Are you single, married, or divorced?

How many times have you been married?

How many children do you have?

What are the ages of your children?

With whom do you live with?

Who makes up your support system (family, friends, etc)?

Did you serve in the military?

If yes, what branch of service, during which years?

Do you have a religious/ spiritual affiliation or belief system?

Have you ever been homeless?

Do you have any current or past significant legal issues (arrests, jail, prison, etc.)?

What is your current insurance coverage?

If you have one, please list your current psychiatrist?

If you have one, please list your current therapist.

Please list any allergies to medications.

Please list any medications (including supplements) you currently take. Please include does and frequency of each medication.

Please indicate if you have experienced any of these symptoms recently. If pain, please note severity (0 lest/10worst).

General		
Good general health lately	Y	N
Fever	Y	N
Weight Change	Y	N
Fatigue/ Lack of energy	Y	N
Excessive sweating	Y	N
Eyes, Ears, Nose, Throat		
Change in vision/ blurring of vision	Y	N
Sensitivity to light	Y	N
Nose or gum bleeding	Y	N
Dry mouth	Y	N
Sore Throat/ difficulty swallowing	Y	N
Cardiovascular		
Chest Pain	Y	N
Palpitations	Y	N
Swelling of the legs or hands	Y	N
Fainting	Y	N
Abnormal EKG	Y	N

Respiratory		
Shortness of breath	Y	N
Coughing up blood	Y	N
Wheezing	Y	N
Loud Snoring	Y	N
Apnea (stop breathing in sleep)	Y	N
Gastrointestinal		
Diarrhea	Y	N
Constipation	Y	N
Nausea	Y	N
Blood in stool	Y	N
Teeth grinding/ jaw clenching	Y	N
Heart burn	Y	N
Pain	Y	N
Musculoskeletal		
Muscle/ joint pain	Y	N
Weakness	Y	N
Change in gait/ falls	Y	N
Skin/ Breasts		
Rash or itching	Y	N
Change in hair	Y	N

Breast pain/ discharge	Y	N
Neurological		
Headaches	Y	N
Lightheaded/ dizzy	Y	N
Seizures	Y	N
Numbness/ tingling	Y	N
Tremor	Y	N
Thick tongue	Y	N
Stiffness/ rigidity	Y	N
Restlessness/ inability to sit still	Y	N
Involuntary movements	Y	N
Endocrine		
Hormone problems	Y	N
Excessive thirst/ urination	Y	N
Heat/ cold intolerance	Y	N
Hematologic/ Lymphatic		
Slow to heal	Y	N
Problems with bruising/ bleeding	Y	N
Genitourinary		
Hesitancy	Y	N
Incontinence	Y	N
Erectile dysfunction	Y	N
Decreased libido	Y	N
Delayed/ inability to reach orgasm	Y	N
Menstrual change/ pregnancy	Y	

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B