

Hill Country MHDD Centers Request for Services

Name: _____
Chart Number: _____

Date: _____ Name of person wanting services: _____

Are you or the person wanting services currently having thoughts of suicide, thoughts to hurt self, or thoughts to hurt someone else?
 YES NO **(If yes, STOP and return form to the front desk)**

Date of Birth: _____ Social Security Number: _____

Physical Address _____ City _____

Zip Code _____ County _____ Home Phone (____) _____ - _____

Cell Phone (____) _____ - _____ Work Phone (____) _____ - _____ Gender: Male Female

Were you told to come here for an evaluation? YES NO

If Yes, by whom? CPS Court Probation Parole Other _____

Are you a Veteran? YES NO Are you the family member of a Veteran? YES NO

List any Insurance: _____

Name of Primary Care Physician: _____

Name of Responsible Person or Guardian (If Applicable): _____

Physical Address of Responsible Person or Guardian _____

Mailing Address of Responsible Person or Guardian _____

Telephone/Cell Number (s) of Responsible Person or Guardian _____

Marital Status	Legal Status	Work/School	Ethnicity
<input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	<input type="checkbox"/> Adult with Guardian <input type="checkbox"/> Adult No Guardian <input type="checkbox"/> Minor <input type="checkbox"/> Minor w/ Conservator	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed <input type="checkbox"/> School/Child <input type="checkbox"/> Retired	<input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Two or more races <input type="checkbox"/> White <input type="checkbox"/> Other _____
Living Arrangement	Primary Language	Live in Colonia	Education – Please indicate the highest level completed
<input type="checkbox"/> Own Home <input type="checkbox"/> Family Home <input type="checkbox"/> Friend's Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Homeless <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Spanish/English <input type="checkbox"/> American Sign <input type="checkbox"/> Unable to Read/Write <input type="checkbox"/> Non-Verbal	<input type="checkbox"/> YES <input type="checkbox"/> NO For Val Verde, Edwards, Uvalde, and Kinney Counties only	<input type="checkbox"/> No School <input type="checkbox"/> Pre-K <input type="checkbox"/> 6 <input type="checkbox"/> GED <input type="checkbox"/> K <input type="checkbox"/> 7 <input type="checkbox"/> Bachelor <input type="checkbox"/> 1 <input type="checkbox"/> 8 <input type="checkbox"/> Master <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> PHD <input type="checkbox"/> 3 <input type="checkbox"/> 10 <input type="checkbox"/> 4 <input type="checkbox"/> 11 <input type="checkbox"/> 5 <input type="checkbox"/> 12

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What brings you here today? _____

What are you wanting to get out of mental health services? _____

Have you ever been told you have a mental health diagnosis? YES NO

If Yes, please name the diagnoses you were given: _____

Have you ever seen a counselor or psychiatrist before? YES NO

If Yes, please name the counselor or psychiatrists: _____

Have you ever been in a psychiatric hospital? YES NO

If Yes, please tell us where and when _____

What medications are you currently taking? _____

What medications have you taken in the past? _____

List any allergies to foods or medications: _____

Tell us about symptoms that are causing difficulties for the person wanting services:

- | | | |
|-------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------|
| <input type="checkbox"/> Prolonged low or sad mood | <input type="checkbox"/> Wanting to hurt others | <input type="checkbox"/> Change in appetite, either too much or too little |
| <input type="checkbox"/> Loss of interest in activities I enjoy | <input type="checkbox"/> Wanting to hurt myself | <input type="checkbox"/> Procrastination |
| <input type="checkbox"/> Change in sleeping patterns, either too much or too little | <input type="checkbox"/> Cutting | <input type="checkbox"/> Trouble being around other people |
| <input type="checkbox"/> Feeling tired all the time | <input type="checkbox"/> Worrying all the time | <input type="checkbox"/> Trouble getting along with others |
| <input type="checkbox"/> Problems thinking or concentrating | <input type="checkbox"/> Trouble leaving my home | <input type="checkbox"/> Problems at work |
| <input type="checkbox"/> Feeling worthless | <input type="checkbox"/> Trouble keeping my home clean | <input type="checkbox"/> Problems with relationships |
| <input type="checkbox"/> Feeling hopeless | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Muscles are always tense |
| <input type="checkbox"/> Thoughts of dying | <input type="checkbox"/> Flashbacks of the past | <input type="checkbox"/> Problems with the law |
| <input type="checkbox"/> Inflated self esteem | <input type="checkbox"/> Thinking I have no future | <input type="checkbox"/> Trouble controlling mood |
| <input type="checkbox"/> No need for sleep | <input type="checkbox"/> Anger | <input type="checkbox"/> Too much energy |
| <input type="checkbox"/> Taking too many risks | <input type="checkbox"/> Irritable most of the time | <input type="checkbox"/> Not enough energy |
| <input type="checkbox"/> Pressure to talk | <input type="checkbox"/> Excessive crying | <input type="checkbox"/> Often missing shower or bath |
| <input type="checkbox"/> Repetitive, compulsive behaviors | <input type="checkbox"/> Trouble staying still | <input type="checkbox"/> Unable to work |
| <input type="checkbox"/> Checking things over and over | <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Unable to go to school |
| <input type="checkbox"/> Problems related to alcohol use | <input type="checkbox"/> Excessive talking | <input type="checkbox"/> Problems in school |
| <input type="checkbox"/> Problems related to drug use | <input type="checkbox"/> Trouble following instructions | <input type="checkbox"/> Bullying others |
| <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Trouble paying attention | <input type="checkbox"/> Being bullied |
| <input type="checkbox"/> Thinking people are out to get me | <input type="checkbox"/> Frequently losing important things | <input type="checkbox"/> Running away |
| <input type="checkbox"/> Thinking people are talking about me | <input type="checkbox"/> Restlessness, need to run, climb, move | <input type="checkbox"/> Frequent lying |
| | <input type="checkbox"/> Interrupting others frequently | <input type="checkbox"/> Stealing |

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What other symptoms exist that cause concern? _____

How do symptoms affect school, work, relationships, or day to day living? _____

Are there any current stressors? _____

What else should we know to help? _____

What are some things you'd like to achieve through the help of mental health services? They can be anything. Examples might be to have more friends, get a job, exercise on a regular basis, stay in school, get passing grades, involve yourself in sports, take care of your home, feel safe, get along with your family. These are just examples. These should be things that are important to you and what you want for your life.

