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 _____

Name of Emergency Contact or Parent, Guardian or Primary Correspondent: _____

Physical Address of Emergency Contact: _____

City, State, Zip: _____ Contact Phone #: (_____) _____ - _____

Relationship to person wanting services: _____ Guardianship Date (if applicable):_____

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

Revised 03-12-2018

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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:

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

_____

_____

_____

_____