PROVIDENCE Health & Services

OUTPATIENT BEHAVIORAL HEALTH ADMISSION DATA

PPMC Providence Portland Medical Center
PSVMC Providence St. Vincent Medical Center

Did you require emergency care prior to your arrival here? ☐ yes ☐ no

Preferred Pronouns: _____

Preferred Name: _____

Emergency Contact

Name:_____

Relationship:_____

Address: _____

Phone: H)_____(W)_____

Medical Providers: Name and Phone Number

Primary Care: _____

Psychiatrist: _____

Therapist: _____

Other: _____

Emergency Hospital Preference:_____

Emergency Dental Preference: _____

Immunizations:

Pediatric	☐ up to date	☐ unknown
Tetanus	☐ up to date	☐ unknown
Pneumonia	☐ up to date	☐ unknown
Influenza	☐ up to date	☐ unknown

Allergies? ☐ yes ☐ no

List Allergies	Reactions
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Latex ☐ Tape ☐ Iodine ☐

Medications ☐ None ☐ Aspirin ☐ OTC/Herbals

Medication	Dose/Frequency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICAL and SURGICAL HISTORY

Do you have or have you ever had:

(Circle those below that apply & write in others)

☐ YES ☐ NO
Eye, ear, nose, throat problems: (glaucoma; lens implants, dentures, loose teeth, dental caps or bridges; wear hearing aids, glasses, contacts or artificial eye)

☐ YES ☐ NO
Heart problems: (chest pain, angina, heart attack, congestive heart failure, irregular heartbeats, pacemaker, defibrillator)

☐ YES ☐ NO
Vascular problems: (high blood pressure, blood clots)

☐ YES ☐ NO
Lung problems: (asthma, emphysema, tuberculosis, coughing, coughing blood, abnormal chest x-ray, sleep apnea)

☐ YES ☐ NO
Gastrointestinal problems: (hepatitis, cirrhosis, ulcers, hiatal hernia, intestinal bleeding, vomiting/diarrhea/constipation +24 hrs, Heartburn)

☐ YES ☐ NO
Genitourinary problems: (OB/GYN, kidney disease/failure, prostrate problems, incontinence, stress incontinence, painful urination, STDs, infections)

Is there any possibility you could be pregnant?
☐ LMP_____ ☐ Birth control_____

☐ YES ☐ NO
Musculoskeletal problems: (back problems, broken bones of neck/back/face, limited range of motion, arthritis, TMJ)

☐ YES ☐ NO
Skin Problems: (rash, hives, bruise easily, open sores)

☐ YES ☐ NO
Neurological Problems: (seizures, paralysis/numb areas, stroke, weakness, dizzy spells, fainting, migraines, confusion, previous head injury)

☐ YES ☐ NO
Psychological condition: (anxiety, depression, bipolar, dementia, Alzheimer's)

☐ YES ☐ NO
Endocrine problems: (diabetes, thyroid)

☐ YES ☐ NO
Anemia/Unusual Bleeding Problems:

Cancer: ☐ YES ☐ NO Type: _____

A bad reaction to anesthesia? ☐ YES ☐ NO

Describe: _____

Family history of high fever or muscle weakness after anesthesia? ☐ YES ☐ NO

A religious objection to blood transfusion? ☐ YES ☐ NO

Surgeries, Implants, Procedures, Hospitalization, Births or Illnesses: (Include dates): _____

_____

_____

_____

Staff Reviewer: _____ **Date/Time:** _____

B. SUBSTANCE USE

Do you use:	No	Yes	How much?	How often?	Date last used?
Alcohol					
Tobacco					
Marijuana					
Cocaine					
Methamphetamines					
Heroin/Opiates					
IV substance					
Others:					

C. PAIN

Are you currently having pain? ☐ No ☐ Yes Pain location_____

Rate your pain using 0-10 with **0=no pain & 10=worst pain**. Circle a number 0 1 2 3 4 5 6 7 8 9 10
Describe your pain_____
Worst pain caused by_____
What relieves your pain?_____

Is your current pain chronic? ☐No ☐ Yes

D. NUTRITION

Do you follow a special diet? ☐ No ☐ Yes describe_____

If you have food allergies, what are they? ☐ N/A_____

Do you have any difficulty eating or chewing? ☐ No ☐ Yes describe_____

Unintentional weight loss of greater than 15 lbs. In the last 3 months? ☐ No ☐ Yes amount_____

Do you feel you have a nutritional problem that prevents you from regaining your health? ☐ No ☐ Yes
Describe_____

E. SAFETY

Do you have concerns about your personal safety? ☐ No ☐ Yes describe_____
_____

Because violence in the home is a serious health risk, we ask everyone:
Are you here today due to injury or illness related to partner violence? ☐ No ☐ Yes

Have you been hit, kicked, punched or otherwise hurt by someone within the past year? ☐ No ☐ Yes

Do you feel unsafe in your current relationship? ☐ No ☐ Yes

Is there a partner from a previous relationship that is making you feel unsafe now? ☐ No ☐ Yes

F. SLEEP

What hours do you normally sleep?_____
Do you nap during the day? ☐ No ☐ Yes Amount: _____

Do you have pre-bedtime rituals or use anything to help you sleep? ☐ No ☐ Yes
If so, what are they?_____

Have you had any recent changes in your sleep patterns? ☐ No ☐ Yes
If so, describe_____

Staff Reviewer: _____ **Date/Time:** _____

G. LEARNING

Concerns that may affect your learning?
☐ None ☐ Difficulty reading ☐ Difficulty hearing ☐ Memory loss ☐ Stress
☐ Non-English speaking ☐ English as a second language ☐ Culture
☐ Learning disability Type: _____ ☐ Other _____
Do you learn better by? ☐ Reading ☐ Listening ☐ Watching ☐ Doing
Is there any health information you need? ☐ Advanced Directives ☐ Current Illness ☐ Diet ☐ Medication
☐ Exercise ☐ Stop Smoking Program ☐ Other_____

H. FUNCTIONING

1. **Mobility:**
   a.) A recent fall to the ground? ☐ No ☐ Yes_____
   b.) Need assistance with walking? ☐ No ☐ Yes_____
   c.) Difficulty going up/down stairs? ☐ No ☐ Yes_____
   d.) Difficulty getting in and out of a chair? ☐ No ☐ Yes_____
2. **Activities of daily living:**
   a.) Do you need assistance with personal hygiene, dressing, or cooking? ☐ No ☐ Yes
   Is so, describe_____
3. **Cognitive Function:**
   a.) Do you have any difficulty speaking, writing, reading, following directions or remembering things? ☐ No ☐ Yes Describe_____
   b.) Are familiar activities sometimes difficult to complete? ☐ No ☐ Yes_____
   c.) Do familiar places sometimes seem unfamiliar? ☐ No ☐ Yes_____
   d.) Have you experienced recent, frequent mood swings that surprise you? ☐ No ☐ Yes
4. **Medications:**
   a.) Are you able to take your medications without the help of others? ☐ No ☐ Yes
5. **Residence:** ☐ Home alone ☐ Home with others: who?_____
   ☐ No permanent residence ☐ Community facility & contact:_____

I. SUPPORTS

Family and Social Treatment Supports:

[Therapist initial below to indicate follow-up, when requested]

Would your family or support persons like more information regarding your treatment? ☐ yes ☐ no _____ Therapist initials

Would you like your family or support persons involved in developing the plan for services here? ☐ yes ☐ no _____ Therapist initials

If yes, whom_____

Would you like your family or support persons like information (re. what to do in an emergency)? ☐ yes ☐ no _____ Therapist initials

Would you like information for support groups for you and your family? ☐ yes ☐ no _____ Therapist initials

Other Support Needs:

Are you concerned about paying for food, medications, transportation, etc? ☐ No ☐ Yes describe_____
_____
Will this treatment stay affect someone at home? ☐ No ☐ Yes who_____
Are you overly anxious or fearful? ☐ No ☐ Yes describe_____
Have you had any personal losses that may impact your care? ☐ No ☐ Yes describe_____
Are you able to contact emergency services when you need them? ☐ Yes ☐ No describe_____
Do you feel you have enough support from family, friends, church, etc? ☐ Yes ☐ No describe_____
Are there spiritual practices that you want us to know about? ☐ No ☐ Yes
Describe_____
Do you have cultural traditions or practices that are important for us to know in providing your care? ☐ No ☐ Yes
Describe_____

Have you served in the military? ☐ Yes ☐ No Branch: _____
Current status: Active ☐ Discharged ☐ Reserves ☐

Check box of person who completed this form:

☐ Patient Signature _____Date/Time: _____

☐ Family/Relationship_____Signature_____Date/Time_____

Staff Reviewer: _____ **Date/Time:** _____