SIERRA VISTA HOSPITAL & CLINICS

800 East 9th Avenue, Truth or Consequences

Hospital: 575.894.2111 Clinics: 575.894.3221

NEW ADULT PATIENT

Behavioral Health

Today's Date: _____ / _____ / _____

Name: _____ Date of Birth: _____ / _____ / _____

Social Security Number: _____ Phone Number: _____

Gender: ☐ Male ☐ Female

Current Address: _____

Primary Language: _____ Criminal Justice Referral: ☐ Yes ☐ No

Legal Guardian

Name: _____ Phone Number: _____

Relationship: _____ Address: _____

Emergency Contact

Name: _____ Phone Number: _____

Relationship: _____ Address: _____

Primary Care Doctor

Name: _____ Phone Number: _____

Clinic Name: _____ Address: _____

Referred by (if any): _____

Are you currently or is there a chance you may be pregnant? ☐ Yes ☐ No

Have you been arrested in the last 30 days? ☐ Yes ☐ No

What is your Primary Source of Income? _____

What is your Primary Source of Payment? _____

History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ☐ Yes ☐ No

If yes, who was your prevous therapist / practitioner? _____

Are you currently taking any prescription medications? ☐ Yes ☐ No

If yes, please list: _____

Safety

Have you had any suicidal / self-harm thoughts recently (in the past month)? ☐ Yes ☐ No

Have you had any suicidal thoughts? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No

Has any immediate family or "extended family" (i.e., aunts, uncles, cousins, Grandparents) or close friends ever attempted suicide? ☐ Yes ☐ No

If you answred "yes" to any of the above, please explain:

_____

_____

Family History

Members of Household

Name	Age	Occupation	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Additional Significant Family Members

Name	Age	Occupation	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Development History

Mother's health during pregnancy:

_____

Parental use of drugs, alcohol, or cigarettes during pregnancy: ☐ Yes ☐ No

Prenatal Care: ☐ Yes ☐ No Postnatal Care: ☐ Yes ☐ No

Were there any complications during pregnancy or delivery? _____

_____

Were there any health problems noted at birth? _____

_____

Were you a full-term pregnancy? ☐ Yes ☐ No

Did you have any of the following?

☐ Delayed / Advanced sitting up ☐ Delayed / Advanced speech

☐ Delayed / Advanced walking ☐ Coordination difficulties ☐ Bed wetting

☐ Other: _____

How is your appetite? ☐ Very good ☐ Good ☐ Satisfactory ☐ Unsatisfactory ☐ Poor

How is your sleeping? ☐ Very good ☐ Good ☐ Satisfactory ☐ Unsatisfactory ☐ Poor

How are your friendships? ☐ Very good ☐ Good ☐ Satisfactory ☐ Unsatisfactory ☐ Poor

How is your activity level? ☐ Innactive ☐ Average ☐ Overactive

How were you nurtured as a child? _____

How were you disciplined as a child? _____

Personal Meical History ☐ **None**

✓	Disease / Conditions	Date of Diagnosis
	Alcoholism/ / Drug use	
	Asthma	
	Cancer (type: _____)	
	Depression / Anxiety	
	Suicidal / Bipolar	
	Diabetes	
	COPD	
	Heart disease (heart attack, murmur, abnormal rhythm)	
	High blood pressure	
	High cholesterol	
	Kidney disease	
	Kidney stones	
	Thyroid disease	
	Migraine / headache	
	Stroke	
	Anemia	
	Stomach issues (ulcers, heartburn, etc.)	
	Liver disease	
	Seizures / Epilepsy	
	Crohn’s disease / Ulcerative Colitis	
	Bleeding issues	
	Prostate issues	

Family Psychiatric History: ☐ **None** ☐ **Unknown**

Please check all that apply	Alcohol/drug use	Anxiety	Depression	Domestic Violence	Eating Disorders	Obesity	Obsessive Compulsive Disorder	Schizophrenia	Suicide Attempts	Other: _____
Mother										
Father										
Brother										
Sister										
Child										
Maternal Grandmother										
Maternal Grandfather										
Paternal Grandmother										
Paternal Grandfather										

Social History

Occupation: ☐ Employed ☐ Student ☐ Disabled ☐ Retired ☐ Unemployed	
Employer / School:	Years of Education / Highest Degree:
Do you enjoy work / school?	
Is there anything stressful about your work / school?	
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Do you have children? ☐ Yes ☐ No If yes, how many: _____ Do they live with you? ☐ Yes ☐ No	
Do you use tobacco? ☐ Yes ☐ No ☐ Cigarettes ☐ Cigars ☐ Vaping ☐ Chewing tobacco	
Answer if CURRENT USER How many per day? _____ How many years? _____ Are you interested in quitting? ____	Answer if FORMER USER Quit date: _____ How many per day? _____ How many years? _____
Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per day? _____	
Do you use any recreational substances? ☐ Yes ☐ No Have you ever used needles to inject drugs? ☐ Yes ☐ No	
Are you sexually active? ☐ Yes ☐ No Birth control method: ☐ None ☐ Condom ☐ Pill ☐ Patch ☐ Ring ☐ Nexplanon ☐ IUD ☐ Depo Provera	
Do you exercise regularly? ☐ Yes ☐ No How long? _____ How often? _____	

Behavioral / Habitual Concerns (Please check all that apply):

☐ Temper Tantrums	☐ Stealing	☐ Fears
☐ Disobedience	☐ Mood Swings	☐ Anxiety
☐ Fine Motor Skills	☐ Attention Span	☐ Eating
☐ Easily Frustrated	☐ Awareness of Danger / Safety Issues	☐ Language / Speech
☐ Clumsiness	☐ Gross Motor Control	☐ Interrupts Adults
☐ Sleeping	☐ Attachment Concerns	☐ Self-Esteem
☐ Restless / Overactive	☐ Memory	☐ Disruptive
☐ Hurts Animals	☐ Fighting	☐ Lack of Empathy
☐ Aggression	☐ Accident Prone	

Other Providers / Specialists ☐ None

Providers / Facility	Specialty	Phone Number

What would you, or others, consider to be your strengths? _____

_____

What would you, or others, consider to be your weaknesses? _____

_____

What do you want to accomplish during therapy sessions? _____

_____

_____