

Mental Health History and Symptoms

Provided by Family Member or Other Concerned Party

This form was developed to help family members and friends provide information to treatment providers about their loved one's mental health history. Individuals making decisions about involuntary psychiatric treatment are required by law to consider historic information provided by family members and others. This requirement is pursuant to California Assembly Bill 1424, which was signed into law effective January 1, 2002. The role of historic information when making involuntary treatment decisions was further clarified and strengthened through additional changes to the law that went into effect January 1, 2016. For more information see "A Guide to California's AB 1424" prepared by the National Alliance on Mental Illness (NAMI) at http://www.namio.org/media/namio/guide_AB1424.pdf.

Present this form to emergency responders or others conducting psychiatric evaluation at the time of crisis and to care providers if your loved one is hospitalized. In order to be the most helpful, fill this form out in advance with current, updated information and have extra copies available.

Today's date _____ Name of person submitting form _____

Relationship to consumer/client _____

Consumer/Client Information

Name _____ Date of birth _____

Phone _____ Address _____

Primary language _____ Religion _____

Medi-Cal: Yes No Medicare: Yes No Other insurance: _____

Does client have a conservator? Yes No Don't know

If yes, name _____ Phone _____

Brief History of Mental Illness (detailed history found in addendum starting on page 5)

Age symptoms or illness began _____

Do you know the client's diagnosis? Yes No Don't know

Please explain _____

Prior 5150 holds? Yes No Don't know

Please explain briefly _____

Prior Hospitalizations? Yes No Don't know

Please explain briefly _____

Name of consumer/client: _____

What has been helpful for client in managing mental illness?

What has not been helpful for client?

Please describe any triggers (events or persons) that can precipitate a crisis.

Does client have a substance abuse problem? Yes No Don't know

Please explain _____

Are there any family traditions, spiritual beliefs, or cultural concerns that are important to know about?

Current Living Situation

Family Independent Homeless Transitional Board & Care Other _____

Is this a stable situation? _____

Treating Psychiatrist and Case Manager/Therapist

Psychiatrist _____ Phone _____

Case manager/therapist _____ Phone _____

Current Medications (Psychiatric and Medical)

Name(s) _____

Medications that have helped _____

Medications that did not help or caused adverse reactions _____

Medical Information

Significant medical conditions _____

Allergies to medications, food, chemicals, other _____

Primary care physician _____ Phone _____

Information Submitted By

Name (print) _____ Phone _____

Address _____

Signature _____ Date _____

*PLEASE NOTE: A person "shall be liable in a civil action for intentionally giving any statement that he or she knows to be false."
Pursuant to Welfare & Institutions Code, Section 5150.05(c).*

Mental Health Symptoms

Please check the boxes indicating symptoms or behaviors your loved one has exhibited in the past and those you're observing now. If only some symptoms in a line apply, please circle them.

<u>Past</u>	<u>Now</u>	<u>Symptom or Behavior</u>
		Gravely disabled (unable to provide food, clothing, and shelter)
<input type="checkbox"/>	<input type="checkbox"/>	▪ Cannot live with family and has no other place to live
<input type="checkbox"/>	<input type="checkbox"/>	▪ Is not capable of safely living in a shelter or board and care (fights, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	▪ Has no income and cannot provide for self
<input type="checkbox"/>	<input type="checkbox"/>	▪ Has no insight into mental illness
<input type="checkbox"/>	<input type="checkbox"/>	▪ Takes clothes off in public places or when inappropriate
<input type="checkbox"/>	<input type="checkbox"/>	▪ Gives clothing away
<input type="checkbox"/>	<input type="checkbox"/>	▪ Dresses inappropriately for the weather
<input type="checkbox"/>	<input type="checkbox"/>	▪ Does not eat food due to irrational beliefs
<input type="checkbox"/>	<input type="checkbox"/>	▪ Eats food that is rotten or objects unfit for human consumption
		Inability to recognize illness and related difficulties
<input type="checkbox"/>	<input type="checkbox"/>	▪ Refuses medication or will not stay on medication
<input type="checkbox"/>	<input type="checkbox"/>	▪ Takes medication inconsistently (takes too many or too few pills)
<input type="checkbox"/>	<input type="checkbox"/>	▪ Does not recognize bizarre behaviors or believe the reports of others
<input type="checkbox"/>	<input type="checkbox"/>	▪ Fails to go to doctor appointments
		Hallucinations
<input type="checkbox"/>	<input type="checkbox"/>	▪ Hears voices or sounds no one else hears
<input type="checkbox"/>	<input type="checkbox"/>	▪ Hears television speaking to him/her (not the actual program)
<input type="checkbox"/>	<input type="checkbox"/>	▪ Laughs or smiles for no apparent reason (responding to internal stimuli)
<input type="checkbox"/>	<input type="checkbox"/>	▪ Sees people, deceased persons, ghosts, or unrecognizable human figures
<input type="checkbox"/>	<input type="checkbox"/>	▪ Sees objects, shadows, eyes, etc. moving around a room
<input type="checkbox"/>	<input type="checkbox"/>	▪ Feels bugs or other objects on skin when nothing is present
<input type="checkbox"/>	<input type="checkbox"/>	▪ Smells odors others don't
		Delusions and responses to delusions (includes grandiose delusions)
<input type="checkbox"/>	<input type="checkbox"/>	▪ Believes he/she is God, religious figure, fictional superhero, etc.
<input type="checkbox"/>	<input type="checkbox"/>	▪ Believes he/she is related to a famous person and tries to visit that person
<input type="checkbox"/>	<input type="checkbox"/>	▪ Falsely believes he/she is extremely wealthy and owns land and buildings
<input type="checkbox"/>	<input type="checkbox"/>	▪ Spends excessive amounts of money due to delusion of being wealthy
		Paranoia and related behavior
<input type="checkbox"/>	<input type="checkbox"/>	▪ Believes people are watching, looking at him/her
<input type="checkbox"/>	<input type="checkbox"/>	▪ Believes government is always watching, F.B.I. is following, etc.
<input type="checkbox"/>	<input type="checkbox"/>	▪ Falsely believes he/she was molested by relatives
<input type="checkbox"/>	<input type="checkbox"/>	▪ Keeps knives near bed due to fear
<input type="checkbox"/>	<input type="checkbox"/>	▪ Believes food is poisoned
<input type="checkbox"/>	<input type="checkbox"/>	▪ Destroys cell phone, TV, etc. because others are listening through them
<input type="checkbox"/>	<input type="checkbox"/>	▪ Afraid to leave home, always peering through window blinds, etc.
		Disorganized speech
<input type="checkbox"/>	<input type="checkbox"/>	▪ Rapid, mumbling speech
<input type="checkbox"/>	<input type="checkbox"/>	▪ Does not make sense in conversation, cannot follow conversation

Name of consumer/client: _____

Past **Now**

Symptom or Behavior

Disorganized behavior

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Leaves stove on, leaves cigarette burning on furniture, etc. |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Inability to correctly use normal life objects (such as eating utensils) |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Parks car in inappropriate places (such as middle of an intersection, parking lot) |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Inappropriate sexual behaviors/boundaries (such as naked or masturbating in public) |

Emotional instability

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Cycles between emotional highs and lows, manic and lethargic behavior |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Becomes extremely agitated without warning |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Threatens to harm others, verbally intimidates others |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Is often depressed and feels hopeless, expresses feelings of worthlessness |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Suicide attempts or suicidal statements |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Cutting or harming self |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Sleeps excessively or does not sleep |

Poor hygiene

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Goes for days without showering, strong body odor |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Very bad breath or decaying teeth |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Soils clothing and shows no awareness or concern |

Inability to understand the concepts of money, worth, or personal property

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Hoarding |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Gives away personal property or money, or family's belongings |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Does not pay for items in stores and just takes things |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Buys junk at yard sales (for high prices) instead of paying important bills |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Goes into other's homes uninvited (to get food, use bathroom, watch TV, etc.) |

Difficulty understanding and following directions

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Cannot process information correctly |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Cannot follow multiple directions |

Inability to maintain gainful employment

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Cannot keep a job |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Blames others for continual problems with tasks or coworkers |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ Cannot develop or maintain relationships with coworkers |

Other symptoms

- | | | |
|--------------------------|--------------------------|---------|
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | ▪ _____ |

Mental Health History

Recent History of Grave Disability:

The legal criteria to hold a person for involuntary treatment beyond 17 days or place him/her on an LPS conservatorship are referred to as “gravely disabled”. Persons are gravely disabled if they are unable to provide for their own food, clothing, or shelter due to a mental disorder. It is very important to know if a person meets these criteria so please describe recent events and behaviors that indicate your loved one is unable to provide food, clothing, or shelter.

* Please note the last line will expand if further room is needed.

Complete Mental Health History:

The table on the next page is for recording the complete mental health history of your loved one so it can be easily reviewed by care providers. This is intended to be a summary of prior crises related to your loved one’s mental illness, not a comprehensive and detailed biography. Symptoms are not included since they are listed on the prior two pages. Here are some directions to help as you complete this information:

1. List the history of all the hospitalizations, incarcerations, periods of homelessness, and any restraining orders which have taken place for your loved one. You are not expected to have access to all of your loved one’s medical history so just list events of which you are aware.
2. List events in chronological order starting with the oldest event.
4. State the diagnosis if known.
5. If you are filling in this table on the computer, just hit the tab key when you are in the last cell at the bottom right and a new row will appear.
6. If you are filling in this table by hand, please print extra copies as needed.
7. The table below has several sample entries to help you get started.

Event Description	Dates (Admission – Discharge)	Hospital Name Contact Person(s)	Diagnosis (Dx), Medications Prescribed (Rx), Other Info.
<i>Hospitalization</i>	<i>June 2005 (3 days) (1st hosp., adolescent)</i>	<i>Heritage Oaks in Sacramento Dr. Jones</i>	<i>Dx: PTSD, anxiety Rx: unknown Assaulted family, damaged property</i>
<i>Homeless</i>	<i>9/2010 - 2/2011</i>		<i>Not taking medications, using meth, beaten up, \$ stolen</i>
<i>Incarcerated</i>	<i>3/2/11 - 6/4/11</i>	<i>Fresno Co Jail</i>	<i>Dx: psychosis NOS Stole from store, assaultive</i>
<i>Hospitalization</i>	<i>8/6/13 - 8/15/13</i>	<i>Psychiatric Health Facility (PHF)</i>	<i>Dx: Schizophrenia, borderline personality Dis. Rx: Lithium, Prolixin</i>

