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.namioc.org/media/namioc/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 _____

_____

Created by the County of Fresno Public Guardian's Office. Pages 1-2 are based on the San Mateo County form titled "Historical Information Provided by Family Member or Other Concerned Party". Rev 8/2017

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).

Name of consumer/client: _____

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.

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

Name of consumer/client: _____

Past	Now	Symptom or Behavior
		Disorganized behavior
☐	☐	▪ Leaves stove on, leaves cigarette burning on furniture, etc.
☐	☐	▪ Inability to correctly use normal life objects (such as eating utensils)
☐	☐	▪ Parks car in inappropriate places (such as middle of an intersection, parking lot)
☐	☐	▪ Inappropriate sexual behaviors/boundaries (such as naked or masturbating in public)
		Emotional instability
☐	☐	▪ Cycles between emotional highs and lows, manic and lethargic behavior
☐	☐	▪ Becomes extremely agitated without warning
☐	☐	▪ Threatens to harm others, verbally intimidates others
☐	☐	▪ Is often depressed and feels hopeless, expresses feelings of worthlessness
☐	☐	▪ Suicide attempts or suicidal statements
☐	☐	▪ Cutting or harming self
☐	☐	▪ Sleeps excessively or does not sleep
		Poor hygiene
☐	☐	▪ Goes for days without showering, strong body odor
☐	☐	▪ Very bad breath or decaying teeth
☐	☐	▪ Soils clothing and shows no awareness or concern
		Inability to understand the concepts of money, worth, or personal property
☐	☐	▪ Hoarding
☐	☐	▪ Gives away personal property or money, or family's belongings
☐	☐	▪ Does not pay for items in stores and just takes things
☐	☐	▪ Buys junk at yard sales (for high prices) instead of paying important bills
☐	☐	▪ Goes into other's homes uninvited (to get food, use bathroom, watch TV, etc.)
		Difficulty understanding and following directions
☐	☐	▪ Cannot process information correctly
☐	☐	▪ Cannot follow multiple directions
		Inability to maintain gainful employment
☐	☐	▪ Cannot keep a job
☐	☐	▪ Blames others for continual problems with tasks or coworkers
☐	☐	▪ Cannot develop or maintain relationships with coworkers
		Other symptoms
☐	☐	▪ _____
☐	☐	▪ _____
☐	☐	▪ _____
☐	☐	▪ _____
☐	☐	▪ _____
☐	☐	▪ _____
☐	☐	▪ _____
☐	☐	▪ _____
☐	☐	▪ _____
☐	☐	▪ _____
☐	☐	▪ _____

Name of consumer/client: _____

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.

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) and Medications Prescribed (Rx)**
Hospitalization	*June 2005 (3 days) (1st hosp., adolescent)*	*Heritage Oaks in Sacramento*	*Dx: PTSD, anxiety Rx: unknown*
Homeless	*9/2010 - 2/2011*		*not taking medications*
Incarcerated	*3/2/11 - 6/4/11*	*Fresno Co Jail*	*Dx: psychosis NOS*
Hospitalization	*8/6/13 – 8/15/13*	*Psychiatric Health Facility (PHF) Dr. Health*	*Dx: Schizophrenia, borderline personality Dis. Rx: Lithium, Prolixin*

Name of consumer/client: _____

Mental Health History

Event Description	**Dates** (Admission – Discharge)	**Hospital Name Contact Person(s)**	**Diagnosis (Dx) and Medications Prescribed (Rx)**

Name of consumer/client: _____

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