Information Provided by a Family Member or Other Support Person

Developed by NAMI Santa Clara County, and members of the community, this form is for family members to communicate about their relative's mental health history pursuant to Assembly Bill 1424. AB 1424, effective January 1, 2002 modifies the Lanterman-Petris-Short Act, which governs involuntary treatment for people with mental illness in California. ***AB 1424 requires those making decisions about involuntary treatment to consider information supplied by family members. After the information has been received and considered, this form will be placed in the client's chart or file.***

Client Information

Client Name: ____ Date of Birth: ________________

Address: ____ Phone: _____________________

Preferred Language: ___________________________ Religion (Optional): _______________________

Medi-Cal: Yes ☐ No ☐ Medicare: Yes ☐ No ☐ Private Insurance: ___________________________

Wellness Recovery Action Plan (WRAP) or Advanced Directive: Yes ☐ No ☐ *(If yes, attach a copy.)*

History of Mental Illness *(age of onset; prior 5150's/hospitalizations; history of violence, self-harm, or unstable living situations. Attach additional pages if necessary.)*

Age symptoms or illness began: ______

Prior 5150's? Yes ☐ No ☐ If yes, how many? ______________________

Prior hospitalizations? Yes ☐ No ☐ If yes, how many? ______________________

Does this client have a conservator? Yes ☐ No ☐ *(If yes, provide name and phone number below.)*

Name of Conservator:____ Phone: ________________

Client's diagnosis, if known: ____

Do you know of any substance abuse problem? Yes ☐ No ☐ If yes, specify: _______________________

Current Medications (Psychiatric and Medical)

Name(s): ____

Medications the client has responded well to: ____

Medications that did not work for the client: ____

Treating Psychiatrist and Case Manager

Agency/Program: ____

Psychiatrist: ____ Phone: ______________________

Case Manager: ____ Phone: ______________________

Medical Information

Significant Medical Conditions: ____

Allergies to Medications, Food, Chemicals, Other: ______________________________

Primary Care Physician: ______________________ Phone: ______________

Current Living Situation ____

____

History of Symptoms

Check all symptoms or behaviors the individual has had in past, and that you are observing now, below.

Symptom or Behavior	Past	Now		Symptom or Behavior	Past	Now
suicide gesture/attempts				weepiness		
suicidal statements				being too quiet		
thinking about suicide				anxious and fearful		
cutting on self				afraid to leave the house		
harming self				giving away belongings		
sleeping too much				increased irritability and/or negativity		
not sleeping				laughing inappropriately		
not eating				stopping medication		
suspicious (paranoia)				repetitive behaviors		
fire setting				forgetfulness		
aggressive behavior (fighting)				not paying bills		
threats				taking more medication than prescribed		
irrational thought patterns (not making sense)				failing to go to doctor's appointments		
destruction of property				spending too much money		
sexual harassing/preoccupation				poor hygiene		
hearing voices				overeating		
lack of motivation				impulsive behavior		
expressing feelings of worthlessness				not answering phone/turning off phone machine		
avoiding others or isolating				talking to self		
talking too much or too fast				substance abuse		
argumentative				homelessness or running away		

Information Submitted By

Name: ______________________ Phone: ______________ Relationship: ____________

Signature: ________________________________ Date: ______________