

Santa Clara County Behavioral Health Services

Information Provided by a Family Member or Other Support Person - Part A

*Developed 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 (LPS 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 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.)

Brief History of Mental Illness (e.g. age of onset, prior 5150's, prior hospitalizations, history of violence, history of self-harm, history of 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 individual has responded well to: _____

Medications that did not work for the individual: _____

Treating Psychiatrist and Case Manager

Agency/Program: _____

Psychiatrist: _____ Phone: _____

Case Manager: _____ Phone: _____

Medical

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			expressing feelings of worthlessness		
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		
anxious and fearful			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: _____