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: _____