

PROBATE COURT OF WAYNE COUNTY, OHIO
LATECIA E. WILES, JUDGE

IN THE MATTER OF _____

CASE NO. _____

CASE HISTORY OF MENTAL ILLNESS

This form is to be completed by the person making application for admission or by any other interested competent person.

1. Full name of patient _____ Social Security No. _____

2. Age _____ Date of Birth: Month _____ Day _____ Year _____ Place _____

3. Race _____ Sex _____ Single Married Widowed Divorced Separated

4. Patient now resides at _____
Street City State Zip County

5. Occupation _____ When and where last employed _____

6. Who is responsible for cost of hospitalization? _____

7. Name and address in full of person to whom correspondence is to be directed _____
Relationship _____

8. Guardian: Name _____ Telephone Number _____
Address _____

9. Name and address of family physician _____

10. Is patient eligible for veteran's benefits? _____

11. Is patient a dependent or spouse of a deceased veteran? _____ If so, state name and S.S.N.:

12. How long have you known this person? _____

13. State what leads you to believe this person is mentally ill _____

14. When was the first sign of mental illness observed by you? _____

15. Are there any legal charges pending on patient, or behaviors that could result in legal proceedings? _____
If yes, explain fully _____

16. Was this person previously stable and well adjusted? _____

17. Number of previous incidents of decompensation where medical/crisis intervention is necessary. _____

18. Has this person been a patient in any hospital, private or public, for the mentally ill, or any other institution? _____
If Yes, state where, and how long? _____

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19. Has this person suffered serious physical injury? (Particularly to the head) _____ If yes explain fully _____

20. Has this person suffered any traumatic incidences or recent stress? _____ If yes, explain fully _____

21. Has this person required forced feeding, seclusion or restraint? _____

If so, explain fully _____

22. Has this person been addicted to the use of alcohol or drugs? _____ If so, explain fully _____

23. Is this person?

Paralytic

Bedridden

Unable to Maintain Proper Hygiene

Violent

Destructive

Excited

Depressed

Homicidal

Suicidal

24. If any of the above are true, describe _____

25. Does this person have any physical defect or deformity? _____

26. Does patient have any medical illness for which ongoing medication and monitoring is required? _____

If yes, explain fully _____

27. Is the patient following doctor's instructions for treatment? _____ List problems _____

28. Interpreter needed Language _____

29. What community services is the person involved in? _____

The above information furnished by _____ Telephone Number _____

Address _____

This information is believed to be true to the best of his or her knowledge.

Date

Applicant