

PROBATE COURT OF FRANKLIN COUNTY, OHIO

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 attacks of mental disorder _____
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? _____

CASE NO. _____

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

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

21. Has this person required 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 Untidy 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 _____

The above information furnished by _____ Telephone Number _____

Address _____

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

Date

Signature