

ASHTABULA COUNTY COURT OF COMMON PLEAS
PROBATE DIVISION
ALBERT S. CAMPLESE, 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 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? _____

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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 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