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## Welcome to Morrow Family Health Center!

Choosing a medical home is a very important decision for your life and the lives of your family.

We are so pleased you chose us for your Behavioral Health needs.

### ***What is Behavioral Health and why is it so important?***

Behavioral health includes your thoughts, feelings, and how you connect with the world. It helps determine how you handle stress, relate to others, and make choices. Behavioral health is important at every stage of life, from childhood and adolescence through adulthood. Good behavioral health helps you cope with problems and enjoy life.

### ***What are Behavioral Health Services?***

Behavioral Health Services include many types of therapy and counseling. They can help you, your child, and/or your family in positive ways. They can help you or your child better understand life situations, change behavior(s), and move toward resolving difficulties. The providers at Morrow Family Health Center use their certified knowledge of human development and behavior to observe situations and make suggestions for new approaches that might help bring positive solutions. For effective outcomes from treatment, it will be important that you or your child examine feelings, thoughts, and behaviors. Also, it is important that you or your child be willing to try new approaches and that you or your child have a willingness for change to occur.

### ***What are possible risks and benefits of treatment?***

The services we offer can have risks and benefits. Since treatment often involves discussing unpleasant aspects of your life or the lives of your family, some risks may include experiencing uncomfortable feelings like sadness, guilt, anger, frustration, and helplessness. If your child is the patient, be aware that he or she may be experiencing these feelings as well. Expected benefits of treatment include: better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees to what you or your child will experience.

### ***What are the techniques and goals of treatment?***

There may be alternative ways to effectively treat the problems you or your child are experiencing. It is important that you discuss any questions you may have regarding any techniques your provider may recommend as treatment options and that you give input into setting the goals for treatment. As treatment progresses, these goals may change. You, your child, and your provider will jointly determine how to effectively meet the goals you are seeking.

### ***What type of relationship with our providers is expected?***

Relationships with the providers of Morrow Family Health Center are *professional* and *therapeutic*. In order to preserve this relationship, it is important that you and the providers not have any other type of relationship. Personal or business relationships undermine the effectiveness of the therapeutic relationship. In order for your care to continue in the most effective, positive manner, providers are not in a position to be a friend. No business, social, or personal relationship, including any social media connection, is allowed between the providers and a patient.

**Thank you for your visit today.**

**Our staff is excited to help you in your medical, dental, and behavioral healthcare needs.**

**Morrow Family Health Center**

**76 S. Main St. Mt. Gilead, Ohio 419-751-9010**

Find us on the web at [www.morrowfamilyhealthcenter.org](http://www.morrowfamilyhealthcenter.org)

Like us on Facebook 

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*To improve the health of our community by providing barrier-free access to medical care.*

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# Behavioral Health

# Adult Health History

To meet all your healthcare needs, please fill out this form completely. This is a confidential record of your medical history.

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Printed Name of Parent or Legal Guardian (If applicable): \_\_\_\_\_

## Hospitalizations

\_\_\_\_\_ Patient denies any hospitalizations

Date	Location	Reason for stay	Length of stay

## Past Medical History – Have you ever had the following:

\_\_\_\_\_ Patient denies any past illness

Condition	Dates	Condition	Dates	Condition	Dates
AIDS		Epilepsy		Pneumonia	
Alcohol		Glaucoma		Prostate Cancer	
Alzheimer's		Heart Disease		Sickle Cell Anemia	
Anemia		Hyper Cholesterol		Stroke	
Arthritis		Hypertension		Suicidal	
Asthma		Hyperthyroidism		TIA	
Birth Defects		Hypothyroidism		Tuberculosis	
Bleeding Disorder		Irritable Bowel		Ulcer	
Cancer		Kidney Disorder		Urinary Tract Infection	
COPD		Liver Disorder		Any other disease	
Depression		Lung Cancer		Any other disease	
Diabetes		Migraine		Any other disease	

## Medications – Please list all medication you are **CURRENTLY TAKING**

\_\_\_\_\_ Patient denies any medications

Current Medications	Dosage (mg)	How often per day

## Allergies – Please list all food, medication, and environmental allergies

\_\_\_\_\_ Patient denies any allergies


Printed name of person completing this form: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_