Adult Intake/Assessment Interview

{Please complete this side of form (unshaded side) only}

DO NOT WRITE IN THIS SECTION FOR STAFF USE ONLY!

DATE: _____ **Sex: M / F**

Patient Name: _____ Birthdate: _____

ALLERGIES: _____

Medications

Please list any medications and dosages you are currently taking (please include over the counter medications, herbals and any nutritional supplements)

1. _____
2. _____
3. _____
4. _____
5. _____

PLEASE USE THE BACK OF THIS PAGE IF YOU NEED MORE ROOM FOR MEDICATIONS

Primary Care Provider: _____

PCP Phone Number: _____

Do you see any specialist: Yes / No

Specialist Name: _____

Specialty: _____ Phone: _____

What do you consider to be the top three stresses in your life?

1. _____
2. _____
3. _____

Mood *(past 1-2* weeks): Calm Happy Sad Anxious Angry Frustrated Worried Hopeless Helpless Other:_____

Behavioral Symptoms *(circle problems in the past month)***:**

Sleep	Enjoying Life	Motivation	Fatigue Guilt	Poor Concentration
Appetite Change		Impulsiveness	Loss of Sex Drive	Racing Thoughts
Can't Stop Talking		Poor Judgment	Strange Thoughts or Behavior	
Periods of Very High Energy			Periods of Very Low Energy	

Mental Health History

1. Have you been in counseling or mental health treatment before? (i.e. Counselor, Psychiatrist, Psychologist, Marriage/Family Counselor). *Yes/No*
2. Have you ever been hospitalized for mental or emotional problems? (For example: nervous breakdown, depression, suicide, mania, schizophrenia, anxiety, drug or alcohol problems, etc) *Yes/No*
3. Has anyone in your family had mental or emotional problems?(e.g. nervous breakdown, depression, suicide, mania, drug or alcohol problems, etc) *Yes/No*
4. Have you ever been referred to Social Services? *Yes/No*

HPI:

Past Mental Health History: *(Previous Psychiatric/Substance Abuse Treatment Inpatient, Outpatient, AA, Family Violence, etc. Include kind of problem, dates, treatment type, length, and who they saw,.)*

HOSPITALIZATIONS:

SUICIDE ATTEMPTS:

PAST TREATMENT:

Family Mental Health History: *(Family Psychiatric/Substance Abuse History)*

IMMEDIATE FAMILY:

EXTENDED FAMILY:

RISK ASSESSMENT (Check appropriate boxes):

	No	Yes	Recently	Today
1. Been so distressed you seriously wished to end your life?...				
2. Have you had or do you have: a. A specific plan how you would kill yourself?……..				
b. Access to weapons/means of hurting self?…….				
c. Made a serious suicide attempt?……				
d. Purposely done something to hurt yourself?…….				
e. Heard voices telling you to hurt yourself? ……...				
3. Had relatives who attempted or committed suicide?…….				
4. Had thoughts of killing or seriously hurting someone?…….				
5. Heard voices telling you to hurt others?……				
6. Hurt someone or destroyed property on purpose?……				
7. Slapped, kicked, punched someone with intent to harm?….				
8. Been arrested or detained for violent behavior?……				
9. Been to jail for any reason?				
10. Been on probation for any reason?				

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Risk: *(Assess suicidal/homicidal intent, plans, hx of attempts, self-mutilation & most violent theing ever.)*

Physical Symptoms:

Physical Symptoms: Circle any that were a problem for you in the last month:

Headaches	*Dizziness*	*Heart Pounding*	*Muscle Spasms*
Muscle Tension	*Sexual Problems*	*Diarrhea*	*Vision Changes*
Numbness	*Tics/Twitches*	*Fatigue Fainting*	*Blackouts*
Chest Pains	*Skin Problems*	*Nausea*	*Chills/Hot Flashes*
Sweating	*Rapid Heart Beat*	*Choking Sensations*	*Stomach Aches*
Shortness of Breath	*Trembling/Shaking*	*Mouth Muscle/Joint Pain*	

Past Medical/Surgical History:

HT: _____ **WT:**_____

If Female: Are you on any form of birth control? Yes/No
Are you, or is there a chance you might be, pregnant? Yes/No
When was your last menstrual period? _____

Medical History: Check all that apply:

	Childhood	Adult	Recently
Serious Illnesses	____	____	_____
Serious Injuries	____	____	_____
Serious Head trauma	____	____	_____

1. Are you allergic to any medications or foods? _____ If yes, please list: _____
_____

2. Do you currently have problems with pain? *Yes/No*
If yes: Where is your pain located? _____
How long have you had this pain problem? _____
What things help your pain? _____
How intense is your pain today? ***(none)*** *0 1 2 3 4 5 6 7 8 9 10* ***(worst)***
Do you ever take more pain medication than prescribed? Yes/No
Are you currently being treated by another doctor for your pain? Yes/No
If yes, who? _____

Nutrition:
Do you purge, restrict, or overeat? *Yes/No*
Have you had any difficulties or concerns related to food intake? *Yes/No*

Social History

1. Are your parents divorced? *Yes/No* If yes, how old were you? _____
2. Briefly describe your childhood (*happy, chaotic, troubled*): _____
   _____
3. Are childhood events are contributing to current problems? *Yes/No*
4. Current Marital Status: *Single Married Divorced Widowed Separated*
5. Number of Years Married: _____ Total Number of Marriages: _____
6. Do you have any children? *Yes/No* Ages? _____
7. Have you experienced any abuse (physical, sexual, verbal) *Yes/ No*
8. How satisfied are you with your current family life? (circle one)
   Very Unsatisfied Un-satisfied Satisfied Very Satisfied

Social Support

How satisfied are you with the support you receive from you family/Friends?
Very Unsatisfied Unsatisfied Satisfied Very Satisfied
Have your current difficulties affected your family/friends/coworkers? *Yes/No*

Quality Of Life: Are you satisfied with your quality of life?
Very Unsatisfied Unsatisfied Satisfied Very Satisfied
What do you do for leisure? _____
Are you able to enjoy leisure/recreational activities? *Yes/No*
If no, why? _____

Education History: Years of education completed? ____ Degree(s) _____

Job History

1. How many jobs: Have you held? _____ Been fired from? _____
2. How satisfied are you with your current occupation?
   Very Unsatisfied Unsatisfied Satisfied Very Satisfied
3. Do you have performance problems or difficulties with boss? *Yes/No*

Alcohol Use: Do or did you:	**In the Past**	**Recently**
1. Regularly use alcohol (more than twice per month)?	*Yes/No*	*Yes/No*
2. Had trouble (legal, work, family) because of alcohol?	*Yes/No*	*Yes/No*
3. Felt you should cut down on your drinking?	*Yes/No*	*Yes/No*
4. Been annoyed by people criticizing your drinking?	*Yes/No*	*Yes/No*
5. Felt bad or guilty about your drinking?	*Yes/No*	*Yes/No*
6. Ever had a drink first thing in the morning	*Yes/No*	*Yes/No*

Other Substance Use/Abuse Do or did you?	**In the Past**	**Recently**
1. Use medications (other than over the counter) that were not prescribed to you?	*Yes/No*	*Yes/No*
2. Taken more than the recommended daily dose of an over the counter medication?	*Yes/No*	*Yes/No*
3. Taken more than the prescribed dose of your prescription medication?	*Yes/No*	*Yes/No*
4. Taken or used any illegal substance?	*Yes/No*	*Yes/No*
5. Used any product or other means to get "high"?	*Yes/No*	*Yes/No*

Habits:.	**In the Past**	**Recently**
1. Do you smoke or chew tobacco regularly?	*Yes/No*	*Yes/No*

2. How many caffeinated drinks do you have per day (coffee, tea, sodas)? _____
3. How often do you exercise per week? _____
   Preferred Exercise: _____
4. Do you have problems with gambling? _____
5. Do you have other potentially harmful habits you want to change? _____
   If so, what? _____ _____

Goals For Treatment

What are your goals for treatment? In other words, what things would you like to see change or be different about yourself?

_____
_____

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Psychosocial History/Issues Warranting Further Attention:*(Abuse , Childhood, developmental, marital, family, occupational, military, housing, spirituality, educational, support & leisure, etc.*)

Family Constellation:

Psychiatric ROS:

Depression:

☐**Mood** ☐**Sleep** ☐**Concentration**
☐**Anhedonia** ☐**Appetite** ☐ **Guilt/Worthless**
☐**SI/HI** ☐**Energy** ☐ **Psychomotor**

Mania:

☐ **Decreased need for sleep with ↑ goal directed behavior:**

☐ **Racing Thoughts:**

☐ **Risk Taking:**

☐**Pressured Speech:**

Phychosis:

☐**A/VH**

☐**Paranoia**

☐**Delusions**

☐ **IOR**

Anxiety:

☐**Worry** ☐**Obsessions**

☐**Panic** ☐ **Compulsions**

Trauma:

☐**Abuse**

☐ **Relive Events**

Eating: ☐**+/- Body Image** ☐ **Restrict/Binge/Purge**

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Plan/Disposition: (*check appropriate boxes, if applicable)*

- ❑ **Follow-up**: (*Who & When):*
  - ❑ Outpatient Treatment_____
  - ❑ Consults / Referral for further evaluation: _____
  - ❑ Refer to therapist/ other Mental Health Care Provider/Finder*:*
  - ❑ Admit to voluntarily/ involuntarily Inpatient Psychiatry:
    - ☐ lmminent dangerousness to self/others
    - ☐ Deteriorating condition despite outpatient management
    - ☐ Other:
  - ❑ Other:
- ❑ **Prescriptions:**

  - ❑ Diagnosis(es), treatment indications, risks, benefits, contraindications, side effects and alternatives were explained and acknowledged by patient/guardian. Handouts provided.

Prevention:

- ❑ Patient agrees to return to clinic sooner if suicidal/homicidal ideations/audiovisual hallucinations/medication problems occur or worsening condition.
- ❑ Patient advised to adhere to treatment plan(s) to prevent early relapse.
- ❑ Patient advised of emergency services and agreed to use them if needed: (if not, explain)
- ❑ Other:

Doctor's Signature:_____

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Substance Abuse Hx: *(As appropriate, include hx of problems, amount, route, age of onset, duration/pattern, tolerance, withdrawal, hx of blackouts, consequences & last use for alcohol, illicit drug use, prescription meds misuse, caffeine, etc.)*

CAGE: __ out of 4

- ☐ **Alcohol**
- ☐ **Cannabis**
- ☐ **Meth**
- ☐ **Benzos**
- ☐ **Hallucuinogens**
- ☐ **Cocaine**
- ☐ **Opiates**

COMPREHENSION ABILITY

Reads/Understands English Yes/No
Understands written instructions? Yes/No
Understands Verbal Instructions? Yes/No
Responds Appropriately? Yes/No

O: Mental Status Exam:

Oriented by:( )Person, ( )Place, ( )Situation, ( )Time
Appearance: Alert, Well groomed, Unkempt, Disheveled, Tearful, Looks: Stated age, Older, Younger
Behavior: cooperative, open, evasive, reserved, cautious, Defensive, Awkward, Restless, Agitated
Mood:

Affect: Full Range, Appropriate, Subdued, Blunted, Constricted, Labile, Other:
Eye Contact: Intense, Good, Moderate, Poor, None
Speech: WNL, Talkative, Rapid, Slow, Stuttering, Loud, Soft, Rambling, Slurred, Pressured, Other:
Thought Process: Normal flow, Loosening of Associations, Disorganized, Suspicious, Racing, Circumstantial, Tangential, Incoherent
Thought Content: WNL, Delusions, Helplessness, Hopelessness, Worthlessness, Other:
Perceptions: WNL, Auditory/Visual/Tactile/Olfactory Hallucinations, Illusions, Other:
Judgment: Intact Fair Impaired Poor
Insight: Good Fair Poor None

Psychological Tests/Rating Scale/Lab Results:

AIMS:
MMSE:

A:

Axis I:

Axis II:

Axis III:

Axis IV: Problems With:
Social Education
Occupation Housing
Finances Access to health care
Legal Other:

Axis V: (GAF Scale)
_____Current _____Past Year

Impairment: _____ Mild/Moderate/Severe
Domains of Impairment: