Revised: Mar. 26, 2008

Demographic Information:

Name: ______________________ Age: ____

Date: ________ Sex: M/F Birth date: ________

Work Phone: __________ Home Phone: __________

Cell Phone: ____________

Home Address:

____

Job/Occupation: ______________________________

Primary Concern: Briefly, what are the problems or concerns that brought you here today?

____

____

____

____

How upsetting is this problem to you? (Circle one)

Not upsetting 0 1 2 3 4 5 6 7 8 9 10 **Severely**

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: ____________

How long have you had this problem? ________

Neurovegetative & 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*

DO NOT WRITE IN THIS SECTION FOR STAFF USE ONLY!

(Examiner shall comment on all pertinent issues, develop by interview any additional history and record significant findings here.)

Time session started: Time ended:

Additional Demographic Information Relevant to Treatment:

S: *(history of present problem & circumstances, e.g. Type, Duration, Frequency, Intensity & Severity of Emotions &/or Behaviors on 0-10 scale, with 0 being no problem and 10 being the most worst ever, SIGECAPS, manic, depressive, psychotic, anxiety dissociative, eating disorder symptoms, etc.)*

S
I
G
E
C
A
P

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,.)*

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

Please check all that apply Have you experienced:	Currently (in the last wk)	Recently (in the last 6 mo.	Previous (over 6 mo. ago)	Never
a. Recurrent thoughts about death				
b. Recurrent thoughts about killing yourself				
c. Recurrent thoughts about killing others				
d. Engagement in self-harm behaviors, such as cutting or burning yourself, without intent to die				
e. Thinking out a plan to kill yourself				
f. Thinking out a plan to kill others				
g. Active preparation to kill yourself; e.g. writing goodbye letter, purchasing pills, obtaining a weapon)				
h. Active preparation/attempt to kill others				
i. Suicide attempt or suicide gesture				
j. Believing that others would be better off if you die				
k. Feeling hopeless about your life and future				
l. A family member or close friend completing suicide				
m. Voices telling you to hurt or kill yourself or others				
n. Being more physically or verbally aggressive than you intended with your spouse or children				
o. A physical altercation in which you caused injury				
p. Throwing or breaking things when angry				

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*	

If Female: Are you/or is there a chance you might be, pregnant? *Yes/No*

Who is your primary care physician? ______________________

Medical History: Check all that apply:

	Childhood	Adult	Recently
Serious Illnesses	___	___	___
Serious Injuries	___	___	___
Serious Head trauma	___	___	___

2. Are you allergic to any medications or foods? *Yes/No*
3. Do you have any physical limitations/barriers/special needs? *Yes/No*
   If yes, please list: ______________________
4. Please list **any medications** and dosages you are currently taking *(include over the counter medication, aspirin, laxatives herbals, vitamins, exercise enhancers, and supplements).*

a.
c.

b.
d.

Pain: Do you currently have problems with pain? *Yes/No*

If yes: Where is your pain located? ______________________

How long have you had this pain problem? ______________________

Briefly describe the pain (*throbbing, achy, dull*) ______________________

What things help your pain? ______________________

How intense is your pain today? *(none) 0 1 2 3 4 5 6 7 8 9 10 (worst)*

FOR STAFF USE ONLY! **(2 of 4)**

Ideation
Frequency
Duration
Intensity
Intent
Plan
Preparation
Rehearsal
Previous Attempts
Other Stressors/Risk Factors

Physical Symptoms:

Past Medical/Surgical History:
(Include kind of problem, dates, treatment type & length, and provider seen

Allergies:

Special TX or Learning Needs:

Current Medications: *(name, dose, dates & for what)*

Pain Assessment:
Location
Intensity
Quality
Duration
Frequency
Helps/Hinders

Nutrition:
Are you on a special diet? *Yes/No*
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 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. Are you currently experiencing abuse (physical, sexual, verbal) *Yes/ No*
8. How satisfied are you with your current family life? (circle one)
Very Dissatisfied Dissatisfied Satisfied Very Satisfied

Sexuality: Are you satisfied with your sex life? *Yes/No*
Do you engage in unprotected sex? *Yes/No*

Social Support
How satisfied are you with the support you receive from your family/Friends?
Very Dissatisfied Dissatisfied Satisfied Very Satisfied
Have your current difficulties affected your family/friends/coworkers? *Yes/No*
What other support systems do you have available?____________________

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

Spirituality: Are you satisfied with your current spirituality? *Yes/No*
Do your current difficulties affect your spirituality? *Yes/No*
What activities do you do for spirituality? ____________________
Optional: What is your religious preference (if any)? ____________________

Financial Life: Are you satisfied with your current financial situation? *Yes/No*
What are your financial concerns? ____________________

Developmental History
1. Were there problems during your birth/delivery? *Yes/No*
2. Did you walk and talk at the same time as your same age peers? *Yes/No*
3. Any memories of physical, verbal or sexual abuse? *Yes/No*
If yes, are those memories bothering you now? *Yes/No*

Education History: Years of education completed? ____ Degrees ________
1. Were you held back or did you fail any grades? *Yes/No*
If yes, which grades?________
2. Did you have any Special Educational services/classes? *Yes/No*
If yes, which grades? ____________________
3. Were you ever suspended in school? *Yes/No*
If yes, how many times? _____
4. Did you get into physical fights in school? *Yes/No*
If yes, how many fights.________
5. While you were in school did you get in trouble with the law? *Yes/No*
6. Is English your primary language? *Yes/No*
7. Do you need a language interpreter? *Yes/No*

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

Military Service History: *(enlistment, duty locations & dates)*

FOR STAFF USE ONLY! **(3 of 4**

Nutrition Concerns:

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

Family Constellation:

Social Support:

Patient Strengths:

Spiritual/Cultural Issues:

Financial Stress: Y / N

Developmental Issues:
Abuse History Y / N

Education History:

Employment History:

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 to steady your nerves or to get rid of a hangover (an "eye opener")	Yes/No	Yes/No

7. What is your drink of choice: ____________________

Drug Use: Do or did you:

1. Use illegal drugs? Yes/No Yes/No

Habits:.

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

If yes, how much? ________

If recently, would you like to quit? 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? Yes/No
5. Do you have other potentially harmful habits you want to change? Yes/No
   Briefly describe: ____________________

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?

1. ____________________
2. ____________________
3. ____________________

Are you motivated to learn new ways to deal with your problems? Yes/No

Which areas of therapy listed, below, might be of interest to you?

( ) Anger Management ( ) Enhancing Self-Esteem
( ) Couples Enrichment ( ) Depression Management
( ) Healthy Thinking ( ) Survivors of Sexual Abuse
( ) Anxiety & Worry Management ( ) Relaxation Training

FOR STAFF USE ONLY!

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

- ❑ **Follow-up:** *(Who & When):*
  - ❑ Individual Therapy ____________________
  - ❑ Group Therapy ____________________
  - ❑ Couples Therapy ____________________
  - ❑ Consults / Referral for further evaluation: ____________________
  - ❑ Admit to voluntarily/ involuntarily Inpatient Mental Health: Facility__________
    Reason:____________________
  - ❑ Other:

- ❑ **Administrative Actions taken:**
  - ❑
  - ❑ Other:

Prevention:

- ❑ Follow-up appointment set for ____________________
- ❑ Return to clinic sooner if problems become worse and client cannot wait until set appointment.
- ❑ 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:

Provider Signature(s)/Stamp(s):

FOR STAFF USE ONLY! (4 of 4)

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

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:

Judgement: Intact Fair Impaired Poor

Insight: Good Fair Poor None

Suicidal: Yes/No

Homicidal: Yes/No

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