Initial Intake Packet

Identifying Information:

Phone #: _____ DOB (DD/MMM/YYYY): ____/____/_____ Age: ____
Name (Last, First, MI): _____ **Date (DD/MMM/YYYY):** _____

Please describe what brought you in today: _____

_____

_____

Did you come Voluntarily? ☐ Yes ☐ No Were you escorted? ☐ Yes ☐ No

In general, how would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Overall, how difficult is it for your to do your work, take care of things at home, or get along with other people? ☐ Not difficult at all ☐ Somewhat ☐ Very ☐ Extremely

Are you currently in pain? ☐ Yes ☐ No

If you answered yes, what is your current *physical* pain level? ___/10 (10 being the worst pain imaginable)

Location of pain: _____

Are you currently in a situation where you are being verbally or physically hurt, threatened, or made to feel afraid? ☐ Yes ☐ No

Learning/Needs Assessment

What is your preferred method of learning? ☐ Verbal ☐ Written ☐ Visual ☐ Other: _____

☐ Yes ☐ No Do you have a learning disability, language barrier, or hearing/vision deficit?
☐ Yes ☐ No Do you have cultural or religious beliefs that may affect care?
☐ Yes ☐ No Are you under a court ordered mental Health Treatment?
☐ Yes ☐ No Are you currently using, or will you be using community resources (i.e. Chaplain, etc.)?
☐ Yes ☐ No Would you like to have family members involved with your care?
☐ Yes ☐ No Have you completed an advanced directive?
☐ Yes ☐ No If yes, do you have a copy of your advanced directive in your record?

Nutritional Assessment

☐ Yes ☐ No Has the illness/condition you're coming in for today led to any changes in the types or amounts of food you eat or has it made it hard to eat?
☐ Yes ☐ No Are you have fewer than 2 meals per day?
☐ Yes ☐ No Have you experiences any unintended weight loss of ten pounds or more in the past six months?

*****Female Patients Only**

Regular periods? ☐ Yes ☐ No When was the first day of your last period? (DDMMMYYYY) _____
Painful periods? ☐ Yes ☐ No Tense, anxious, or depressed before periods? ☐ Yes ☐ No
Number of pregnancies: ____ Number of live births: ____ Currently pregnant? ☐ Yes ☐ No

Check if you have been experiencing any of the following symptoms in the past month in regard to what brings you in today:

☐ Depression	☐ Irritability	☐ Recent loss; grief
☐ Low self-esteem	☐ Forgetfulness	☐ Sense that others are putting thoughts in my mind
☐ Tenseness	☐ Financial problems	☐ Obsessive thoughts (certain thoughts run through your mind excessively, you can't control it)
☐ Recurrent thoughts about past trauma	☐ Gambling problems	
☐ Low motivation	☐ Sexual problems	☐ Compulsive rituals (excessive checking, cleaning, counting, etc.)
☐ Low concentration	☐ Excessive spending	
☐ Changes in sex drive	☐ Distrustfulness	☐ Hearing/seeing things others don't
☐ Restlessness (pacing)	☐ Loneliness	
☐ Feeling "numb"	☐ Don't like being touched	☐ Eating disorder (intentional vomiting, overuse of laxatives, overeating, undereating, etc.
☐ Angry outbursts	☐ Racing thoughts	
☐ Can't have fun	☐ Impulsivity	
☐ Insomnia (trouble falling asleep)	☐ Risk-taking behavior	
☐ Legal troubles	☐ Worries/Fears	
☐ Avoiding people	☐ Increased conflicts	
☐ Excessive sleeping	☐ Social anxiety	
☐ Nightmares	☐ Sense that I have powers	
☐ Tearfulness	☐ Feel watched	
☐ Fatigue	☐ Feel picked on	

Substance Use History

Tobacco: Do you use tobacco products? ☐ Yes ☐ No If yes, what type? _____

Amount used in one week? _____

Caffeine: Cups of coffee/day ____; Cans of soda/energy drinks ____; Cups of tea/day ____

Drugs: List any illegal substances you have used: _____

Alcohol: How often do you drink? ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Not at all

On average in ***one*** sitting, how many alcoholic drinks do you have? (Fill in below)

Shot(s) of hard liquor ___; Mixed drink(s) ___; Can(s)/Bottle(s) of beer ___; Glasses of wine ___

Please read the statements below and mark "Yes" or "No" as it applies to you:

☐ Yes ☐ No Have you ever tried to cut back on your alcohol use?

☐ Yes ☐ No Do you feel annoyed or angered when questioned about your alcohol use?

☐ Yes ☐ No Have you ever felt guilty about your alcohol use?

☐ Yes ☐ No Have you ever needed an "eye-opener" to get started in the morning?

☐ Yes ☐ No Have you ever blacked out (can't remember events) after heavy drinking?

☐ Yes ☐ No Have you ever been referred to SACO/DAPA or Base SAP?

☐ Yes ☐ No Have you ever been treated for alcohol or other substance addiction/abuse?

General History

Where were you raised (City, State)? _____ What birth order are you? ___ of ____

# of brothers/half-brothers/step-brothers: ____/____/____

# of sisters/half-sisters/step-sisters: ____/____/____

Are your parents still together? ☐ Yes ☐ No If no, how old were you when they divorced/separated? ____

Who primarily raised you? ☐ Mother ☐ Father ☐ Step-mother ☐ Step-father ☐ Other: _____

Describe your relationship with your parent(s): _____

_____

How would you describe your childhood in one word? _____

Did you experience any abuse during childhood? (Physical, emotional, sexual, neglect) If yes, please explain:

_____

Did you have any conflict with your teachers or peers throughout the school? ☐ Yes ☐ No

Highest level of education? ☐ High School ☐ 2-Year Degree ☐ 4-Year Degree ☐ Master's Degree or higher

Most recent GPA? _____

Do you have any history of domestic violence in any relationships? ☐ Yes ☐ No

Current Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If unmarried, are you in a relationship? ☐ Yes ☐ No If married, how long have you been married? _____

Length of relationship prior to marriage: ____ Have you or your partner been married before? ☐ Yes ☐ No

Spouse/Partner's Occupation:

_____

Check all that apply with your current relationship:

☐ Close and trusting	☐ Alcohol abuse	☐ Physical/emotional abuse
☐ Trust issues	☐ Distant but loyal	
☐ Poor communication	☐ Sexual problems	☐ Cold and hostile

General History (cont.)

Do you have any children? ☐ Yes ☐ No If yes, please list age/gender: _____

_____

Any involvement with Family Advocacy Program (FAP)/Child Protective Services? ☐ Yes ☐ No
If yes, please explain: _____
Are you currently facing or do you have past legal or disciplinary issues? ☐ Yes ☐ No
List your hobbies, and any participation in community or religious/spiritual organizations: _____

_____

_____

What is your religion (if any)? _____
Would you like assistance finding spiritual resources? ☐ Yes ☐ No

Mental Health History

Have you ever been seen by Mental Health before? ☐ Yes ☐ No
If yes, list what for, any diagnoses, treatment, and medication: _____

_____

Medical History

Have you ever been hospitalized? ☐ Yes ☐ No If yes, explain: _____

_____

Current medical prescriptions (name, dose, purpose): _____
Current supplements (vitamins, protein, etc.): _____
Do you have any known food or medication allergies? ☐ Yes ☐ No If yes, explain: _____

Family Medical and Mental Health History

Have anyone in your family ever struggled with or had treatment (including therapy, medicine, hospitalization) for psychological or substance abuse problems? ☐ Yes ☐ No
If yes, explain their relation to you and their diagnosis and treatment: _____

_____

Has anyone in your family ever committed suicide? ☐ Yes ☐ No
If yes, explain: _____
Are there any significant medical problems that are prevalent in your family? ☐ Yes ☐ No
If yes, explain: _____

Deployment History (If you have never deployed, leave this page blank)

How many combat deployments? _____ How many non-combat deployments? _____

Deployment 1:
From (MM/YYYY): ___/_____ To (MM/YYYY): ___/_____ Unit: _____ Deployed to? _____
Was this deployment ☐ combat or ☐ non-combat? During this deployment, did you sustain any injuries or were you exposed to any traumatic events? ☐ Yes ☐ No
If yes, explain: _____

Deployment 2:
From (MM/YYYY): ___/_____ To (MM/YYYY): ___/_____ Unit: _____ Deployed to? _____ Was this deployment ☐ combat or ☐ non-combat? During this deployment, did you sustain any injuries or were you exposed to any traumatic events? ☐ Yes ☐ No
If yes, explain: _____

Deployment 3:
From (MM/YYYY): ___/_____ To (MM/YYYY): ___/_____ Unit: _____ Deployed to? _____ Was this deployment ☐ combat or ☐ non-combat? During this deployment, did you sustain any injuries or were you exposed to any traumatic events? ☐ Yes ☐ No
If yes, explain: _____

Deployment 4:
From (MM/YYYY): ___/_____ To (MM/YYYY): ___/_____ Unit: _____ Deployed to? _____ Was this deployment ☐ combat or ☐ non-combat? During this deployment, did you sustain any injuries or were you exposed to any traumatic events? ☐ Yes ☐ No
If yes, explain: _____

Please check any of the following that you have experienced while on a deployment:

☐ Had contact with IEDs, RPGs, mortars/rockets that were within distance to cause me to feel the overpressure
☐ IDF
☐ Involved in a vehicular accident/crash
☐ Blacked out/had a loss of consciousness of _____ (seconds/minutes/hours)
☐ Received a head injury that caused: confusion/seeing stars/other changes in vision/nausea/vomiting
☐ Diagnosed with a concussion in theater
☐ Participated in direct combat
☐ Had to discharge a weapon toward insurgents
☐ Witnessed the loss of a friend/acquaintance who was killed or seriously injured
☐ Directly involved with care, transportation, recovery, or security of the body of a friend/acquaintance
☐ Witness coalition forces, villagers, or insurgents killed or seriously injured
☐ Handled injured victims' body parts, or dead bodies

Risk Assessment

Have you ever thought about suicide? ☐ Yes ☐ No
Are you currently thinking about suicide? ☐ Yes ☐ No
Are you thinking of a plan to kill yourself? ☐ Yes ☐ No
If yes, explain: _____

_____

Have you ever tried to kill yourself or harm yourself in the past? ☐ Yes ☐ No
If yes, explain: _____

_____

What are a few reasons or thoughts that might prevent you from acting on your suicidal thoughts (if applicable)? _____

_____

Please check any of the following that apply to you at this time:

☐ Yes ☐ No Suicidal thoughts	☐ Yes ☐ No Family history of mental illness
☐ Yes ☐ No Developed plan to commit suicide	☐ Yes ☐ No Loss of a loved one
☐ Yes ☐ No Intent to commit suicide	☐ Yes ☐ No Suicide of a relative/peer
☐ Yes ☐ No Let others know about suicidal thoughts	☐ Yes ☐ No Recent stressful life event
☐ Yes ☐ No Access to methods to kill myself	☐ Yes ☐ No Chronic stressors (financial, legal, etc.)
☐ Yes ☐ No Seeking means to kill myself	☐ Yes ☐ No Current psychological trauma
☐ Yes ☐ No Taken steps to commit suicide	☐ Yes ☐ No Childhood trauma (sexual, emotional, physical)
☐ Yes ☐ No Substance abuse	☐ Yes ☐ No Stressful medical condition
☐ Yes ☐ No Hopelessness	☐ Yes ☐ No Chronic pain
☐ Yes ☐ No Purposelessness	☐ Yes ☐ No Physical functional impairment
☐ Yes ☐ No Anger	☐ Yes ☐ No Military related stress
☐ Yes ☐ No Recklessness/Impulsivity	☐ Yes ☐ No Past homicidal thoughts
☐ Yes ☐ No Feeling trapped	☐ Yes ☐ No Past homicidal actions
☐ Yes ☐ No Feeling withdrawn from others	☐ Yes ☐ No Current homicidal thoughts
☐ Yes ☐ No Anxiety	☐ Yes ☐ No Past violent episodes
☐ Yes ☐ No Mood changes	☐ Yes ☐ No Current violent thoughts or urges
☐ Yes ☐ No Sleep related issues	☐ Yes ☐ No Intent to act on thoughts or urges
☐ Yes ☐ No Guilt/shame	☐ Yes ☐ No Saving up medication
☐ Yes ☐ No Self-injurious behavior	☐ Yes ☐ No Family history of homicide
☐ Yes ☐ No Harming or killing animals	☐ Yes ☐ No Are you seeing or hearing things others do not see or hear?
☐ Yes ☐ No Family history of suicide attempts	

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score = _____

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

(For office coding: Total Score T_____