Integrated Healthcare, L.L.C.
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MENTAL HEALTH ASSESSMENT

Date: _____

Last Name: _____ First Name: _____ MI: _____

Social Security Number: _____/ _____ / _____ email: _____

Legal Guardian (If applicable):

Name: _____ Relationship: _____ Contact #: _____

Previous Address:

Home Address: _____ City: _____ State: _____ Zip code: _____

Home phone #: _____ Mobile phone#: _____ Work Phone #: _____

Current Address:

Home Address: _____ City: _____ State: _____ Zip code: _____

Home phone #: _____ Mobile phone#: _____ Work Phone #: _____

Please list the names and phone numbers of people you wish for us to leave a message which in case we are unable to reach by phone or email:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Date of birth: _____ Age: _____ Sex: _____ Religion: _____

Race: _____ Ethnicity: _____ Other (specify): _____

Birthplace: _____ Primary language spoken: _____ Education: _____

Current Occupation: _____ Previous Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

Number of times married _____.

Current Insurance

Are you the primary cardholder? ☐ Yes ☐ No If not, please complete information below:

Name of Insurance: _____

Policy/Member ID#: _____ Group #: _____

Name of Card holder: _____ Date of birth: _____

Social Security Number: _____ Email address: _____

Home address: _____

Home Phone: _____ Mobile phone: _____ Work phone: _____

Are you claiming disability? ☐ Yes ☐ No

CHIEF COMPLAINT

Reason for this visit? When did the problem? _____

_____

_____

_____

Briefly explain what you expect from this treatment (if you do not know, then state that):

_____

_____

_____

_____

How did you hear about us? _____

PAST PSYCHIATRIC HISTORY

Have you ever been hospitalized for psychiatric illness? _____

If yes, please provide dates and reason(s): _____

OTHER THERAPIES

Name of therapist or agency: _____

Address:

Street Address: _____ City: _____ State: _____ Zip Code: _____

Dates and reason(s) for seeking help:

_____

_____

_____

_____

_____

_____

_____

PHARMACY INFORMATION

Allergies: _____ **Height: _____ Weight: _____**

Name: _____ Phone #: _____ Fax#: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

CURRENT MEDICATIONS

(Medications that you are taking now – Please add another sheet if necessary)

Medication	*Dosage*	*How taken*	*Start date*	*Purpose*	*Response*	*Side effects (if any)*	*Name of prescribing clinician and specialty*

PAST MEDICATIONS

(Medications that you took in the past but no longer take – Please add another sheet if necessary)

Medication	*Dosage*	*How taken*	*Stop date*	*Purpose*	*Response*	*Side effects (if any)*	*Why did you stop taking this medication?*

FAMILY HISTORY

Please list any blood relatives who were treated for mental or nervous disorders. Please include medications they were treated with and whether the medications helped them.

How related	Mental or nervous disorder	Medication(s)	Did they help?

MEDICAL HISTORY

Allergies: _____ Are you currently under a physician's care? _____

Date of last physical exam: _____

Name of healthcare provider: _____ Phone #: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

If you are under a provider's care, do you wish that a copy of your progress report be sent to your physician? Yes: ☐ No: ☐

Current health status: Excellent: ☐ Fair: ☐ Good: ☐ Poor: ☐

Height _____ Weight: _____ Blood Pressure: _____

Summary of current health concerns:

Summary of past health status (childhood illnesses, serious or chronic illnesses, serious accidents or injuries, hospitalizations, operations, obstetrical):

Hospitalization for Medical/Psychiatric problems – Please add another sheet if needed

Admission Date	Hospital	Reason(s)	Discharge Date

FAMILY HISTORY

FAMILY CONSTELLATION

Nuclear family (the family in which you were raised): _____

_____

_____

_____

Your parents are: □Married □Separated □Divorced □Widowed □Remarried □Never married

Number of brothers: _____ Number of sisters: _____

Number of step-brothers: _____ Number of step-sisters: _____

You are (check all that apply):

□ Only child	□ Youngest child	□ Middle child	□ Oldest Child
□Step child	□ Adopted child	□ Foster child	

FAMILY LIFE

Please describe your home situation: _____

_____

_____

_____

FAMILY COMPOSITION

(Persons living in the household)

Name	How related	Age	Sex	Race	Education	Occupation

FAMILY MEDICAL HISTORY

Directions: please mark on the chart below, your blood relative(s) history of the following disease(s): Cancer, Diabetes, Heart disease, Hypertension, Epilepsy (or seizure disorder), Emotional stresses, Endocrine diseases, Sickle cell anemia, Kidney disease, Unusual limitations, and other chronic problems.

Name of relative	*Relationship*	*Age*	*Sex*	*Living/deceased*	*Illness/cause of death*

FAMILY MENTAL HEALTH HISTORY

Please list the blood relatives (parents, siblings, aunts, uncles, cousins, grandparents, etc.) who you know have/had or you suspect may have/had mental or nervous disorder(s). Include treatments and their effectiveness (if known).

Relationship	*Disease(s)*	*Medications if known*	*Medications effective?*
	Depression		
	Manic Depression/Bipolar		
	Eating Disorder		
	Alzheimer's		
	Personality Disorder / Antisocial		
	Attention Deficit Disorder (ADD or ADHD)		
	Schizophrenia		
	Substance Abuse		
	Alcoholism		
	Mental Retardation		
	Anxiety/Panic		
	Other		

Family history of suicide attempts or completed suicides: _____

_____

_____

_____

Family history of homicide attempts or completed homicides: _____

_____

_____

_____

SOCIAL HISTORY

Please describe your usual day: _____

_____

_____

Sleep habits: _____

_____

_____

Dietary habits: _____

_____

_____

Exercise habits: _____

_____

_____

_____

Hobbies or special interests: _____

_____

_____

_____

Usual Vacation: _____

_____

_____

_____

SUPPORT SYSTEMS

Availability of Family: _____

_____

_____

Community: _____

_____

_____

Other: _____

_____

_____

OCCUPATION AND FINANCIAL STATUS

Financial Sources: _____

_____

Adequacy: _____

_____

Recent changes in resources and/or expenditures: _____

_____

_____

Career goals (if applicable): _____

_____

_____

LEGAL ASSESSMENT

Any past, current, or future legal problems or concerns? (Please list any arrests or convictions and dates if applicable: _____

_____

_____

_____

_____

SUBSTANCE ABUSE HISTORY

Substance	Yes	No	Route of Administration	Amount	Frequency	Comments
Caffeine						
Tobacco, nicotine						
Alcohol						
Opioids (morphine, codeine) methadone, dilaudid, heroin, aka smack or horse)						
Cocaine (coke, snow, baby, powder)						
PCP (phencyclidine), angel dust, hog						
Inhalants (spray can, propellants, paint products, solvents, glue, gasoline, cleaning fluid)						
Marijuana, cannabis (grass, pot, hashish)						
Sleeping pills						
Tranquilizers						
Stimulants						
Hallucinogens (lysergic acid diethylamide aka LSD or acid, peyote, psilocybin, mescaline)						
Sedatives, hypnotics, anxiolytics, (secobarbital sodium {Seconal}, pentobarbital sodium {Nembutal}, methaqualone {Quaalude}, diazepam {Valium}, alprazolam {Xanax}, chlordiazepoxide {Librium}						
Amphetamines {uppers, crank, speed)						
Barbiturates						

Have you ever experienced withdrawal symptoms? □ Memory Loss □ Blackouts □ Seizures

DEVELOPMENTAL/PSYCHOSOCIAL HISTORY

(If under 18 years old, please skip this page)

What were you like as a teenager? _____

_____

_____

_____

Describe yourself as to what sort or type of person you are normally: _____

_____

_____

_____

Describe your strengths: _____

_____

_____

_____

What do you like best about yourself?: _____

_____

_____

What do you like least about yourself?: _____

_____

_____

What is your mood normally?: _____

_____

_____

General statement of your feelings about yourself: _____

_____

_____

Feelings of satisfaction or frustration in interpersonal relationships: _____

_____

_____

Feelings of depression: _____

_____

_____

(Parent/foster parent may complete this section for patient under 18 years of age)

Have you ever had thoughts of hurting or killing yourself? Yes _____ No _____

If you answered yes to the question above, please answer the following items:

	Yes	No
1. Have you been having any disturbing or gloomy thoughts?		
2. Have any of these thoughts been desperate ones?		
3. Have you ever wished you were dead?		
4. Have you thought about harming yourself?		
5. Have you actually made plans to take your own life?		
6. Have you ever made a suicide attempt?		

State of anxiety and behavior demonstrating it: _____

_____

_____

_____

Changes in personality, behavior, mood (please describe): _____

_____

_____

_____

_____

Are you willing and able to change?: _____

_____

_____

_____

What are you willing to do to change or accept matters?: _____

_____

_____

_____

_____

Have you ever experienced any of the following? (If you answered yes to any of the following, please explain briefly):

1. Child abuse: _____
2. Sexual abuse: _____
3. Physical abuse: _____
4. Emotional abuse: _____

COPING PATTERNS

How do you handle stress?: _____

_____

_____

_____

How do you handle anger?: _____

_____

_____

_____

Reactions to joyful situations: _____

_____

_____

_____

Reactions to stressful situations: _____

_____

_____

_____

Do you use or have you used substances (alcohol, drugs) to alter your emotional response(s)?:

_____

_____

_____

Please describe recent changes or stresses in your life: _____

_____

_____

_____

CULTURAL AND RELIGIOUS ASSESSMENT

Ethnic and religious preference: _____

_____

_____

_____

_____

Length of time family has lived in the United States: _____

Language(s) spoken at home: _____

_____

Traditional dietary habits and dress: _____

_____

_____

_____

_____

Participation in worship and related activities: _____

_____

_____

_____

State your religious beliefs about the following:

Birth: _____

Death: _____

Health: _____

Illness: _____

(If over 18 years old, you are finished - please skip this section)

SCHOOL LIFE

Tell us about your:

1. Classmates: _____
2. Teachers: _____
3. Subjects: _____

DEVELOPMENTAL MILESONES

Birth Weight: _____ Complications of birth: _____

Pregnancy planned?: _____

Bonding: _____

Age walked: _____ Age talked: _____ Age sat up: _____

Behavior toward caretakers: _____

_____

_____

Behavior towards others: _____

_____

_____

Hospitalizations: (List most recent first) Date(s):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Reason for hospitalization: _____

_____

Surgery (s): _____

_____

Problems related to surgery: _____

_____

_____

CURRENT HEALTH STATUS

Weight loss/gain_____

Infectious diseases: (Please list): _____

_____

_____

_____

Recent infections: (check and date the conditions that apply)

□ Cold _____ □ Nausea/vomiting _____ □ Sore throat _____ □ Cold/

Diarrhea _____ □ Ear infection _____ □ Fungal infection _____

□ Other: _____

Recent injuries: (check and date the conditions that apply)

□ Cuts/bruises _____ □ Scars _____ □ Rashes _____

□ Fracture _____ □ Scrapes _____

Physical problems or disabilities: (check and date the conditions that apply)

□ Glasses _____ □ Hearing aid _____ □ Prosthesis _____

□ Braces _____ □ Any restrictions due to the above? _____

Summary of current health concerns: _____

_____

Thank you for taking the time to complete this form. This information will be kept confidential and will be used for the sole purpose of your evaluation.