

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

Date: _____

PATIENT NAME:

Last Name: _____ First Name: _____ MI: _____

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

Current Address:

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

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

Previous Address:

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

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

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

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

Birthplace: _____ Primary language spoken: _____ Education: _____

Current Occupation: _____ Previous Occupation: _____

Marital Status: Single Married (*Number of times?*) _____ Separated Divorced

Are you the primary cardholder? Yes No (if no fill out information below.

Relationship: _____ Address if different: _____

Legal Guardian (If applicable):

Name: _____ Relationship: _____ Contact #: _____

Insurance:

PRIMARY CARD HOLDER:

Last Name: _____ First Name: _____ MI: _____

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

Date of Birth: _____ Current Address: _____

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

Employer name and address: (if applicable): _____

How did you learn about us? _____

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):

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)

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

PAST MEDICATIONS

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

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

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:

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):

<input type="checkbox"/> Only child	<input type="checkbox"/> Youngest child	<input type="checkbox"/> Middle child	<input type="checkbox"/> Oldest Child
<input type="checkbox"/> Step child	<input type="checkbox"/> Adopted child	<input type="checkbox"/> Foster child	

FAMILY LIFE

Please describe your home situation: _____

FAMILY COMPOSITION (Persons living in the household)

Name	How related	Age	Sex	Race	Education	Occupation

	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
<i>Caffeine</i>						
<i>Tobacco, nicotine</i>						
<i>Alcohol</i>						
<i>Opioids (morphine, codeine) methadone, dilaudid, herion, aka smack or horse)</i>						
<i>Cocaine (coke, snow, baby, powder)</i>						
<i>PCP (phencyclidine), angel dust, hog</i>						
<i>Inhalants (spray can, propellants, paint products, solvents, glue, gasoline, cleaning fluid)</i>						
<i>Marijuana, cannabis (grass, pot, hashish)</i>						
<i>Sleeping pills</i>						
<i>Tranquilizers</i>						
<i>Stimulants</i>						
<i>Hallucinogens (lysergic acid diethylamide aka LSD or acid, peyote, psicybin, mescaline)</i>						
<i>Sedatives, hypnotics, anxiolytics, (secobarbital sodium {Seconal}, pentobarbital sodium {Nembutal}, methaqualone {Quaalude}, diazepam {Valium}, alprazolam {Xanax}, chlordiazepoxide {Librium})</i>						
<i>Amphetamines (uppers, crank, speed)</i>						
<i>Barbiturates</i>						

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.