Southeast Kansas Mental Health Center

ADULT INTAKE ASSESSMENT[1]

This information is part of your confidential medical record. Your answers are important to providing the best possible treatment. Please answer as many questions as possible. Mark any questions you prefer to answer in person.

Clinician Use Only: *ID:* _____ *Date:* _____
Time In/Out: _____ *Units:* _____
Intake Assessment, Code ☐ *ADMN (New) or* ☐ *ADMR (Reopen)*

IDENTIFYING INFORMATION

Client Name: _____ DOB: _____ Age: _____

☐ Male ☐ Female Height: _____ Weight: _____ lbs.

Distinguishing physical characteristics (i.e., hair color, disabling condition, etc.): _____

_____

Physical Aids Present (i.e., glasses, cane, walker, hearing aid, etc.): _____

_____

Cultural Identity: _____

How long in area? _____ Type of Residence: _____

Who referred you?

☐ self
☐ family member
☐ mental health professional
☐ ad in phone book
☐ agency
☐ Other _____
☐ friend
☐ law enforcement
☐ physician/nurse
☐ minister
☐ co-worker

PRESENTING PROBLEMS

What is the MOST SIGNIFICANT problem or reason you are seeking help today? _____

_____

How would you rate the severity of this problem? ☐ mild ☐ moderate ☐ significant ☐ extreme

How long have you had this problem? _____

How often does the problem occur? ☐ constantly ☐ daily ☐ weekly ☐ monthly ☐ less often

On the next page are some common problem areas for adults. To help focus on the most important issues, please complete the following checklist.

[1]Adapted from instrument of Western Arkansas Counseling and Guidance Center, Ft. Smith, Arkansas (2005), used with permission.

1) ☑ Check only **Problem Areas** with moderate or greater distress.
2) For each checked, also check the level of **Distress**, how long this has been a problem (**Duration**) and how often problem **Occurs**.

	PROBLEM AREAS	**DISTRESS**			**DURATION**					**OCCURS**				
		Moderate	Significant	Extreme	Less than 6	12	24	over 24	months	Constantly	Daily	Weekly	Monthly	Less often
☐	Anger Management / Temper	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Antisocial Behavior/Legal System	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Anxiety or Panic	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Attention/Concentration Problems	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Childhood Trauma or Abuse	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Chronic Pain/Physical Problems	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Couple Problems	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Dependency	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Depression	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Eating Disorder	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Family Conflict	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Functioning in Daily Living Skills	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Impulse Control	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Job Related Stress	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Losing Touch With Reality	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Low Self-Esteem	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Manic or “Hyper”	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Obsessive and/or Compulsive	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Paranoid or Suspicious	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Parenting Problems	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Phobias/Fears	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Posttraumatic Stress	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Sexual Abuse	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Sexual Confusion or Behavior	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Sexual Dysfunction	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Sleep Disturbance	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Social Discomfort	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Social Skills	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Spiritual Confusion	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Substance Abuse/Dependence	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Suicidal Thoughts/Attempts	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Thinking Problems	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Unresolved Grief/Loss	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Other:	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Other:	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐

Has there been:
Suicide thinking or attempts ☐ In the last month? ☐ Today ☐ _____

Thoughts of harming others or attempts ☐ In the last month? ☐ Today ☐ _____

In what ways have the problems troubled you? _____

_____

What do you hope to get from treatment?_____

_____

What do you expect from your treatment team? _____

_____

What do you think your role in treatment will be? _____

Who else, such as family members or friends, will be involved in your treatment? _____

_____

What **problems** or **needs** do you have that might hinder treatment or ability to reach your desired goals?

_____

What **preferences** do you have regarding your treatment program at Southeast Kansas Mental Health Center? For example, is there a service that you do not want?

_____

Is there a court order to receive treatment? ☐ yes ☐ no

STRENGTHS, ABILITIES, NEEDS & PREFERENCES

What are **three (3)** resources **(strengths)** that will help in your treatment?

☐ Family Support	☐ Network of Friends	☐ Spiritual
☐ Employment	☐ Stable Finances	☐ Available Transportation
☐ Intelligence	☐ Good Health	☐ Other: _____

You possess many different **abilities** that can be utilized to help overcome your problems. What are **six (6)** of your abilities that may be most useful in your treatment? I . . .

☐ take medication	☐ am assertive	☐ express thoughts and feelings
☐ work cooperatively with others	☐ provide leadership	☐ abstain from alcohol/drugs
☐ request help from others	☐ resolve conflicts	☐ analyze problems
☐ use self-help materials	☐ keep appointments	☐ develop solutions to problems
☐ follow directions	☐ complete tasks assigned	☐ manage time effectively
☐ maintain consistent behavior	☐ other: _____	☐ other: _____

DAILY ACTIVITIES[2]		Mark the following (S) if STRENGTH Or (L) if LIMITATION If neither, leave blank
1. Personal Care	Present self as generally clean, e.g., bathes, showers, brushes teeth.	
2. Grooming	Care for general appearance, hair, hands, makeup, shaves.	
3. Dress	Wear clean clothes, in good repair, comfortable for the weather, activity.	
4. Household Stability	Contribute to and maintain stable housing; organize possessions, clean, comply with house rules if living with others.	
5. Physical & Mental Health	Manage or assist with health issues, known health problems, medical appointments, medications as prescribed, weight, mood changes.	
6.Communicates	Listen & respond to people; express feelings, especially anger effectively	
7. Safety within environment	Focus attention: safe vision, hearing, & adequate memory; avoid high-risk places, misuse of knives, matches, razors, appliances, dangerous household substances.	
8. Managing Time	Rarely tardy or absent for work, appointments, adequate task management, follow regular sleep periods, mealtimes.	
9. Managing Money	Manage money wisely, control spending habits and responsible with money; e.g., no thefts, no shoplifting, assists or pays bills on time, etc.	
10. Nutrition	Eat at least 2 nutritious meals, good snacks	
11. Problem Solving	Make decisions; resolve basic problems of daily living; clarify instructions, ask questions for clarity, setting expectations.	
12. Family Relationships	Get along with family, significant others; contribute to positive relationships with spouse, parent, sibling, child, significant other/ family	
13. Alcohol, Drug Use	Avoid misuse or, where prescribed, abstain from alcohol, beer, taking illegal drugs, high risk mix of multiple substances and cigarettes.	
14. Leisure Entertainment	Enjoy a variety of activities with others & alone; e.g., watch & play sports, TV, books, magazines, arts, crafts, movies, board games, music, dance, and radio.	
15. Community Resources	Use community or public assistance services: self-help groups, religious organizations, shops/stores, MARTA bus/trains, library, job help lines.	
16. Peers/Social	Get along with friends, neighbors, co-workers, peers of like age.	
17. Sexual Behavior	Exhibit appropriate behavior towards others such as respects self and peers' sexual privacy; no sexually harassing, exploiting behaviors.	
18. Productivity and work	Independently work or volunteer, complete homemaking, childcare responsibilities, participate in school, learn skills for financial self-support.	
19. Coping Skills	Know diagnosis/symptoms of illness; use different options for coping, feel ok about self; regain self control reasonably well under stress.	
20. Behavior Norms	Exhibit self-control over verbal or physical anger, abusive, threatening, anti-social, dangerous, violent, nuisance or bizarre behaviors. Law-abiding.	

[2]Adapted from Daily Living Activities Scale, Will Pressmanes, with permission

What **problems** or **needs** do you have that might hinder your treatment or ability to reach your desired goals?

_____

What **preferences** do you have regarding your treatment program at Southeast Kansas Mental Health Center?

_____

_____

FAMILY OF ORIGIN

You were raised by? ☐ parents ☐ parent/step-parent ☐ single parent ☐ Other _____

List any developmental problems you recall experiencing such as premature birth, bedwetting, slow physical development, speech problems, delayed sexual development.

_____

What do you think about how you were raised?_____

_____

What kind of relationship do you have today with those who raised you? _____

How many brothers or sisters do you have? _____

What kind of relationship did do you have with your brothers and sisters?_____

_____

Did those who raised you, or your brothers/sisters have mental health or drug/alcohol problems? What about extended family?

_____

What problems did you have as a child or adolescent? (mental health, drug/alcohol, neglect, abuse, etc.)

_____

What significant issues about your childhood would you add to this information?

SEXUAL HISTORY (Reminder: You may choose not to answer any of the following questions)

Did your family or school provide sex education? ☐ yes ☐ no
Have you engaged in sexual behavior? ☐ yes ☐ no
Were you prepared to enter into a sexual relationship? ☐ yes ☐ no
Have you ever been forced to have sexual contact? ☐ yes ☐ no When? _____
Have you ever contracted a sexually transmitted disease? ☐ yes ☐ no
Have you participated in High-Risk behavior for HIV? ☐ yes ☐ no
(multiple sexual partners, or a partner with multiple sexual partners, shared needles, homosexual behavior)
What other significant sexually oriented problems do you wish to discuss?

EDUCATIONAL HISTORY

What is the last grade you completed? ☐ 6th or less ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED

College: ☐ freshman ☐ sophomore ☐ junior ☐ senior ☐ masters ☐ doctorate

Any specialized or technical training (i.e., cosmetology, welding, etc.)? _____

Are you currently pursuing your education? ☐ yes ☐ no What field of study? _____

What was your average grade during your last three years of schooling? ☐ A ☐ B ☐ C ☐ D ☐ F

What problems with learning did you have? _____

Did you have testing to assess for learning disabilities or ADHD problems? _____

Were you in resource or special education classrooms? _____

How well did you get along with teachers? _____

What other significant education related information do you want to add?

MILITARY SERVICE

☐ Check here if never in the military Which branch did you serve in? _____ For ____ Years

Why did you leave? _____

What problems did you experience in the military? _____

What type of discharge did you receive? _____

What significant military related information do you want to add?

EMPLOYMENT, FINANCES AND LEISURE

Are you currently: ☐ employed ☐ unemployed ☐ laid off ☐ on disability How long?_____

Where did you last work (or currently work)? _____

What was/is your position there? _____

Where did you work the longest? _____ How long? _____

How many jobs have you had in the last 5 years? _____

What problems have you had on the job? _____

What problems related to finances do you have? _____

What interests, activities, or hobbies do you pursue in your free time? _____

_____

What significant employment or financial related information do you want to add?

FAMILY AND SIGNIFICANT RELATIONSHIPS

Marital Status? ☐never married ☐married ☐divorced ☐separated ☐widow(er) ☐living as married

How many times have you been married?_____ How long each time?_____

Spouse Name:_____DOB:_____Age:_____

Is spouse employed? ☐ yes ☐ no Employer:_____ Position:_____

Total number of children: ___his ___hers ___ours. If children live with you, please give:

Name: _____ Age___ Sex___ ☐ his ☐ hers ☐ ours

Name: _____ Age___ Sex___ ☐ his ☐ hers ☐ ours

Name: _____ Age___ Sex___ ☐ his ☐ hers ☐ ours

Name: _____ Age___ Sex___ ☐ his ☐ hers ☐ ours

With whom do you live?_____

What problems exist in your current intimate relationship? _____

_____

What problems do you have with your children?_____

How many close friends do you have? _____ How well do you get along with others? _____

To what organizations, clubs or teams do you belong? _____
What significant family or interpersonal relationship information do you want to add?

SPIRITUAL BACKGROUND

With what religion do you identify?
☐ None ☐ Christianity ☐ Judaism ☐ Islam ☐ Buddhism ☐ Taoism ☐ Native American
☐ Other: _____

Are you a member of a local religious group? ☐ yes ☐ no Which one? _____
How active are you? ☐ extremely ☐ very ☐ somewhat ☐ not at all
How important is your faith? ☐ extremely ☐ very ☐ somewhat ☐ not at all

What problems have you had regarding spiritual issues? _____

How might your faith/spirituality help you overcome your problems? _____

Is there any spiritually related information you would like to add?

LEGAL HISTORY (Reminder: You may choose not to answer any of the following questions)

Have you ever been arrested or taken to court? ☐ yes ☐ no
Have you ever been placed in a correctional institution? ☐ yes ☐ no When? _____ How Long? _____

Juvenile arrests?_____

Adult arrests? _____

What are your current legal issues or problems? _____

_____

MEDICAL HISTORY

Have you had any of the following symptoms in the past 60 days?

☐ Ankle Swelling	☐ Coughing	☐ Lightheadedness	☐ Penile Discharge	☐ Urination Difficulty
☐ Breathing Difficulty	☐ Pulse Irregularity	☐ Memory Problems	☐ Cramps	☐ Bedwetting
☐ Vomiting	☐ Vision Changes	☐ Seizures	☐ Vaginal Discharge	☐ Blood in Stool
☐ Muscle Weakness	☐ Shakiness	☐ Dizziness	☐ Nervousness	☐ Diarrhea
☐ Mole/Wart Changes	☐ Tremor	☐ Falling	☐ Sleep Problems	☐ Constipation
☐ Hair Change	☐ Nosebleeds	☐ Confusion	☐ Gait Unsteadiness	☐ Sweats (Night)
☐ Hearing Loss	☐ Chest Pain	☐ Panic Attacks	☐ Numbness	☐ Sweats (Other)
☐ Headaches	☐ Tingling in Arms & Legs	☐ Loss of Consciousness	☐ Rash	☐ Bleeding gums

Pregnant? ☐ yes ☐ no If yes, expected delivery date _____
Hospitalized in last three (3) years? ☐ yes ☐ no If yes, where and why _____

_____

Allergies/Drug Sensitivity: ☐ None ☐ Food _____

☐ Medication _____ ☐ Other _____

Weight Change in last year by more than five (5) pounds? ☐ yes ☐ no If yes, how much (+/-) _____

Any of the following:

Problem	Now	Past	Never	Medical Treatment Date(s)
Anemia				
Arthritis				
Asthma				
Bleeding Disorder				
Blood Pressure (High or Low)				
Bone/Joint problems				
Cancer				
Cirrhosis / Liver Disease				
Diabetes				
Epilepsy / Seizures				
Eye Disease / Blindness				
Fibromyalgia / Muscle Pain				
Glaucoma				
Headaches				
Head Injury / Brain Tumor				
Hearing Problems / Deafness				
Heart Disease				
Hepatitis / Jaundice				
Kidney Disease				
Lung Disease				
Menstrual Pain				
Oral Health/ Dental				
Stomach / Bowel Problems				
Stroke				
Thyroid				
Tuberculosis				
AIDS/HIV				
Sexual Transmitted Disease				
Learning Problems				
Speech Problems				
Anxiety				
Bipolar Disorder				
Depression				
Easting Disorder				
Hyperactivity / ADD				
Schizophrenia				
Sexual Problem				
Sleep Disorder				
Suicide Attempts / Thoughts				

ALCOHOL & DRUG USE AND TREATMENT (You may choose not to answer any of the following questions.)

CATEGORY	AGE STARTED	AGE STOPPED OR CURRENT	AVERAGE FREQUENCY IN PAST YEAR	AVERAGE AMOUNT USED EACH TIME	COMMENTS
ALCOHOL (beer, wine, liquor)					
CAFFEINE (coffee, tea, soda, "No-Doze," etc.)					
NICOTINE (cigarettes, chew, snuff, cigars, pipe)					
STIMULANTS (cocaine, crack, crank, speed, amphetamines, methamphetamine, pseudoephedrine, ephedrine)					
CANNABIS (marijuana, hashish, hash oil)					
SEDATIVE HYPNOTICS (barbiturates, ie, Seconal, Phenobarbital; benzodiazepines, ie, Valium, Xanax, sleeping pills; Quaalude, Doriden)					
HALLUCINOGENS (LSD, PCP, mushrooms, ketamine, ecstacy, MDMA)					
INHALANTS (glue, paint, solvents, rush, gasoline, white out)					
OPIOIDS (opium, morphine, heroin, codeine, methadone)					
OTHER (dextromethorphan, steroids, etc.)					

What treatment have you had for Alcohol/Drug related problems? ☐ none ☐ AA/NA
☐ outpatient treatment ☐ residential treatment ☐ detoxification ☐ hospitalization

Where? _____
Other substance use related information you would like to add?

MENTAL HEALTH HISTORY & TREATMENT

☐ Check here if you have never been in mental health treatment

OUTPATIENT TREATMENT HISTORY

Treated By:	From: Date to Date		For What Problems?	Results of Treatment

PSYCHIATRIC HOSPITALIZATIONS

Hospital:	From: Date to Date		For What Problems?	Results of Treatment

PSYCHIATRIC MEDICATIONS

Medication	Amount	Prescribed By:	Taken From Date to Date		Results of Treatment

What mental health related information would you like to add?

After completing treatment, how do you plan to maintain progress? _____

_____

Thank you for taking the time to complete this background information. Please place this in the envelope provided, put your name on the outside and seal envelope to insure privacy. Bring to your appointment.