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.

IDENTIFYING INFORMATION

Client Name: _____ DOB:_____ Age:_____

☐ Male ☐ Female ☐ Other_____

Who referred you?

☐ self
☐ family member
☐ mental health professional
☐ minister
☐ co-worker
☐ friend
☐ law enforcement
☐ physician/nurse
☐ agency
☐ other_____

PRESENTING CHALLENGE

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

_____

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

How long have you had this challenge? _____

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

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

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

What is on goal you have for yourself by seeking treatment?

_____

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

_____

What **would you like** regarding your services at Southeast Kansas Mental Health Center? For example, is there a service or medical treatment 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
☐ Employment
☐ Intelligence
☐ Network of Friends
☐ Stable Finances
☐ Good Health
☐ Spiritual
☐ Available Transportation
☐ 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: _____

Who would you want to make care decisions for you if you could not?

How do you want people to treat you?

What do you want your loved ones to know if something happens to you?

For additional information on Advanced Directives: Kansas Advance Directives (wichitamedicalresearch.org)

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? _____

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 challenges? What about extended family?

_____

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

_____

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

_____

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

Have you been impacted by a traumatic event or experience? ☐ yes ☐ no When? _____
Have you ever been forced to have sexual contact? ☐ yes ☐ no When? _____
Have you participated in High-Risk behavior for HIV? ☐ yes ☐ no
(multiple sexual partners, or a partner with multiple sexual partners, shared needles)
Would you like to share more about your trauma history that you may 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? _____

Did you have any testing or supports for your schooling?
☐ Individual Education Plan ☐ 504 Plan ☐ ADHD testing ☐ Special Education ☐ Learning Disability

How well did you get along with teachers? _____

MILITARY SERVICE

☐ Check here if never in the military.

Which branch and job did you serve in? _____ For ____ Years

Why did you leave? _____

What challenges 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?_____

Partner/Spouse Name:_____DOB:_____Age:_____

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

Total number of children: ___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? _____

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 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? _____

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 (please check)?

☐ Ankle swelling	☐ Pulse Irregularity	☐ Lightheadedness	☐ Sleep Problems
☐ Breathing Difficulty	☐ Nervousness	☐ Memory Problems	☐ Cramps
☐ Vomiting	☐ Vision Changes	☐ Seizures	☐ Gait Unsteadiness
☐ Muscle Weakness	☐ Shakiness	☐ Dizziness	☐ Numbness
☐ Coughing	☐ Tremor	☐ Falling	☐ Bedwetting
☐ Hair Change	☐ Nosebleeds	☐ Confusion	☐ Diarrhea
☐ Hearing Loss	☐ Chest Pain	☐ Panic Attacks	☐ Constipation
☐ Headaches	☐ Tingling in limbs	☐ Loss of Consciousness	☐ Other_____

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 (+/-) _____

Check any of the medical conditions that apply:

☐ Anemia	☐ Arthritis	☐ Asthma	☐ Blood Pressure	☐ Bone/Joint Pain
☐ Cancer current	☐ Cancer past	☐ Cirrhosis/Liver Disease	☐ Diabetes	☐ Epilepsy/Seizures
☐ Eye Disease/Blindness	☐ Fibromyalgia	☐ Glaucoma	☐ Head Injury/Brain Tumor	☐ Heart Disease
☐ Hepatitis/Jaundice	☐ Kidney Disease	☐ Lung Disease	☐ Oral Health/Dental	☐ Stroke
☐ Thyroid	☐ Tuberculosis	☐ Anxiety	☐ Depression	☐ Other_____

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

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

When and where? _____

SUBSTANCE USE	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, energy drink,"No-Doze," etc.)					
NICOTINE (cigarettes, vaping, chew, snuff, cigars, pipe)					
CANNABIS (marijuana, hash, edibles, hash oil)					
OTHER (methamphetamine, cocaine, prescription drugs, etc) _____					
OTHER_____					

MENTAL HEALTH HISTORY & TREATMENT

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

MENTAL HEALTH TREATMENT (Outpatient and/or inpatient) HISTORY

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

MEDICATIONS (Current and past)

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

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