Mental Health Intake Assessment

Mental Health Intake Assessment

Date of Service: _____ dd / mm / yyyy

Medical Service Billing Code: 90801 Mental Health Intake Assessment

Completed by: _____ **Time In:** _____

Time Out: _____ **Therapy Style:** _____

IDENTIFYING INFORMATION

Identifying Information

Contact Information

Is client insured?

◯ Yes ◯ No

Payor Source Info

Primary Email Address: _____ **Service Type:** _____

Billing / Admin Partner: _____ **Mailing Address (if Different):** _____

1(A). CHIEF COMPLAINT

1(a). Chief Complaint

Use the box below to transfer the presenting circumstances to the client's record in CarePatron.

1(B). SYMPTOM CHECKLIST

1(b). Symptom Checklist

- [ ] Depressed feelings / sad or down
- [ ] Grief or sadness over recent loss
- [ ] Feelings of guilt
- [ ] Withdrawing from friends or social activities
- [ ] Feelings of anxiety, panic or worry
- [ ] Reduced ability to concentrate / poor attention or focus
- [ ] Feeling overwhelmed or paralyzed
- [ ] Ritualized / repetitive checking behaviors
- [ ] Changes / problems w/ diet & appetite
- [ ] Violent Outburts / Physical or Verbal lashing out at others
- [ ] Night terrors / other sleep disturbances
- [ ] General relationship problems involving intimate partner or partner(s)
- [ ] Issues related to sexuality / sexual preference / sexual orientation
- [ ] Sexual trauma
- [ ] Increased reliance on drugs or alcohol
- [ ] Experiencing auditory or visual hallucinations
- [ ] Other Somatic symptoms
- [ ] Other Option not listed
- [ ] Feeling tired / low energy / lacking motivation
- [ ] Loss of pleasure
- [ ] Problems getting to sleep / staying asleep
- [ ] Cyclical mood changes (High highs or low lows)
- [ ] Intrusive / Disturbing / Unwanted thoughts
- [ ] Irrational fears or phobias causing distress in daily life
- [ ] Inability to relate to others / develop relationshionships / connect interpersonally
- [ ] Excessive anger / irritability / agitation
- [ ] Binging and/or Purging behaviors
- [ ] Flashbacks / Preoccupation with painful memory
- [ ] Excessive Hair-pulling or skin picking
- [ ] Relationship problems involving infidelity / broken trust
- [ ] Sexual dysfunction / loss of libido / hypersexuality
- [ ] Problems with gender / gender dysphoria
- [ ] Dissociation - Feeling disconnected from reality
- [ ] Suicidal ideation(s)
- [ ] Other Psychotic symptoms

Alcohol & Drugs

Suicidal Ideation (s)

Somatic Sxs

Psychotic Sxs

Other Option not listed

2. Have you been treated for these or related symptoms in the past?

◯ Yes ◯ No

If yes:

3. Is there a known history of mental illness within your immediate family?

◯ Yes ◯ No

If yes:

4. Have you experienced any major events that you think might be traumatizing?

◯ Yes ◯ No

If yes:

5. Are you currently being treated for any medical condition(s)?

◯ Yes ◯ No

If yes:

6. Are any of the conditions mentioned in question 4 chronic?

◯ Yes ◯ No ◯ N/A (Not applicable)

If yes:

☐ Read the following statement. If true, check the box below and then skip to Section 1.6. I am not currently prescribed any medications by a doctor or psychiatrist nor am I currently taking any that have been prescribed in the past

7(a). Have you ever been prescribed medication for a mental health condition such as Prozac?

◯ Yes ◯ No

If yes:

7(b). Current Medications

Read the following statement. If true, check the box below and then skip to Section 2.2. I do not currently use drugs or alcohol, nor do I have any history of having used them in the past

8(a).

8(b).

- Marijuana / THC / Cannabis
- Alcohol (Beer, Liquor, Hard Ciders)
- Methamphetamine
- Fentanyl
- Hallucinogens
- Inhalants
- Khat
- LSD (Acid)
- GHB
- Over the Counter Medicine - Loperamide
- Prescription Opioids (Oxy/Percs)
- Psilocybin (Magic Mushrooms / Shrooms)
- Salvia
- Synthetic Cannabinoids (K2/Spice)
- Other
- Tobacco (Cigarettes, Vaping, Chewing Tobacco)
- Cocaine / Crack
- Central Nervous System Depressants (Benzodiazepines)
- Ayahuasca, Mescaline (Peyote)
- Heroin
- Ketamine
- Kratom
- MDMA (Ecstasy / Molly)
- Over the Counter Medicines (Dextromethorphan (DXM)
- PCP (Angel Dust)
- Prescription Stimulants (Speed)
- Rohypnol (Roofies)
- Steroids (Anabolic)
- Synthetic Cathinones (Bath Salts / Flakka)

8(c).

9. Is there a history of drug abuse, alcoholism or any other addiction that runs in your family?

Yes No

If yes:

10. Has there ever been a time in your life when you thought you ought to cut back on your use

Yes No

If yes:

11. Are there other areas in your life in which your behaviors could have addictive potential, such as pornography or gambling?

◯ Yes ◯ No

If yes:

12. Do you ever think about suicide or your own death, even if it just a passing thought or fantasy and/or daydream?

◯ Yes ◯ No

If yes:

13. In the past month have you seriously considered taking action to end your life, or have you felt that things would be better off if you were dead?

◯ Yes ◯ No

If yes:

14. Have you ever attempted suicide in the past?

◯ Yes ◯ No

If yes:

15.Do you currently wish to use harm or death, directly or indirectly to someone else?

◯ Yes ◯ No

If yes:

16. Do you feel threatened or unsafe either at home, at work or at school?

◯ Yes, at home ◯ Yes, at work or at school ◯ No

If yes:

17(a).

17(b).

18. What are your current living arrangements?

- ◯ Private Residence (Apartment, House, Condo)
- ◯ Homeless Shelter
- ◯ Group Home
- ◯ Sober Living Community
- ◯ Prison, Jail or Halfway House
- ◯ Student Housing
- ◯ Skilled Nursing Facility
- ◯ None; Homeless
- ◯ Other

More details:

19. With whom do you reside?

- ☐ Spouse / Partner(s)
- ☐ Roommate(s)
- ☐ Parents, In-Laws or Other Family
- ☐ Friend(s)
- ☐ Children or Step-Children
- ☐ Pet(s)
- ☐ N/A (I live alone)
- ☐ Other

More details:

20. Do you have individuals in your life whom you trust and who you consider to be part of your support system?

◯ Yes ◯ No

If yes:

21. Do you have any involvement in community activities (such as social groups, clubs, churches or associations)?

◯ Yes ◯ No

If yes:

22. Did you graduate high school or did you obtain a GED?

◯ Yes, Graduated ◯ Yes, Obtained GED ◯ No

If no:

23. Did you attend any college or Post-Secondary Education?

◯ Yes ◯ No

If yes:

24. Did you earn any diplomas, degrees, certificates, or credentials?

◯ Yes ◯ No

If yes:

25. Were there any intellectual / cognitive impairments, learning disabilities, or other ways that learning was hard?

◯ Yes ◯ No

If yes:

26. Are you currently employed / working?

◯ Yes, Full-Time ◯ Yes, Part-Time ◯ No / Unemployed

If yes:

27. Is there a defined industry that you specialize in or a type of work where you have worked the longest?

◯ Yes ◯ No

If yes:

28. Have you ever served in any branch of the military (armed services)?

◯ Yes ◯ No

If yes:

☐ Read the following statement. If true, check the box below & skip to Section 3.7. I have no history of arrests or any other legal issues aside from minor traffic violations

29. Have you ever spent any length of time in jail or prison?

◯ Yes, Jail ◯ Yes, Prison ◯ No

If yes:

30. Do you have any pending charges, upcoming court cases, outstanding warrants, records that have been sealed by the court or past offenses that have been either expunged or exonerated?

◯ Yes ◯ No

If yes:

31. Do you have any misdemeanors or felonies on your adult record?

◯ Yes, Felonies ◯ Yes, Misdemeanors ◯ No

If yes:

32. Does the nature of your offenses require that you register as a sex offender?

◯ Yes ◯ No

If yes:

33. Are you currently on probation, parole, or house arrest?

☐ Yes, probation
☐ Yes, parole
☐ Yes, house arrest
☐ No, none of the above

If yes:

34. How would you describe your gender identity?

- [ ] CIS-gender
- [ ] Transgender
- [ ] Non-binary
- [ ] Other Non-Conforming

If not CIS-gender:

35. By which pronouns do you prefer to be addressed?

- [ ] He/Him/His
- [ ] She/Her/Hers
- [ ] They/Them/Their
- [ ] Ze/Hir/Hirs
- [ ] Ze/Zir/Zirs
- [ ] Xe/Xem/Xyr
- [ ] Other

If other:

36. How might you describe your sexual orientation?

- [ ] Straight / Heterosexual / Opposite gender loving
- [ ] Gay / Lesbian / Homosexual / Same-gender loving
- [ ] Bisexual / CIS-gender loving
- [ ] Pansexual / All gender loving
- [ ] Asexual / Not attracted sexually to others
- [ ] Other

If other:

37. Are you currently in a relationship?

- ◯ Yes
- ◯ No

If yes:

38. Are you divorced, separated, or widow/widowered to a former spouse?

◯ Yes ◯ No

If yes:

39. Do you consider yourself poly (or capable of having a relationship with more than one individual at a time)?

◯ Yes ◯ No ◯ Don't know / Undecided

If not yes:

40. In how many romantic relationships have you been that you consider to be significant?

◯ 5+ ◯ 3-4 ◯ 1-2 ◯ None

More details:

41. Do you have any children, whether naturally conceived or conceived with medical assistance; and/or whether involved or uninvolved in their upbringing?

◯ Yes ◯ No ◯ Don't know / Uncertain

If not no:

42. Which of the following best describe your spiritual beliefs?

- ☐ Religious
- ☐ New Age
- ☐ Atheist
- ☐ Agnostic
- ☐ Spiritual
- ☐ Other

More details:

43. Do you have any recreational interests or hobbies?

◯ Yes ◯ No

If yes:

44. Let's talk about your strengths and weaknesses. What are your very best qualities and characteristics? What are good or skilled at doing? As far as challenges go, what are your vulnerabilities, weaknesses, or areas rife for development? Finally, are there any barriers you can foresee that might prevent you from committing to the therapeutic process? List them in the grid below.

45. If any barriers were identified above, have you problem-solved actions that can be made to address them proactively?

◯ Yes ◯ No ◯ N/A ; No barriers identified

If yes:

4.1(A) SUMMARY

4.1(a) Summary

Use the box below to transfer the interpretive summary to the client's permanent record in CarePatron.

4.1(b) Assessment Administered

- ☐ PHQ - 9
- ☐ GAD - 7
- ☐ Sondermind Functional Assessment (if applicable)
- ☐ Other (Please clarify)

4.2(a). Diagnosis

ICD-10 Codes

4.2(b). Diagnoses to be Ruled Out / Further Investigated:

4.2(c). Reported / Unconfirmed Historical Diagnos(es)

Goal 1

Goal 2

Goal 3

Goal 4

Use the boxes below to transfer client's stated goals to the client's permanent record in CarePatron.

List recommendations for treatment below.

4.(a). Has an appointment for follow-up been scheduled?

◯ Yes ◯ No

If no:

4.(b). Date: _____ dd / mm / yyyy **Time?:** _____

4.(c). Appointment Type and Location (if applicable).

◯ Office Location (1100 Spring St. NW Ste 380, Atlanta GA 30308)
◯ Telehealth Location (Doxy / Sondermind / Sessions / Zoom / Teams) ◯ Other

- END OF ASSESSMENT -

- END of ASSESSMENT -

ATTESTATION

☐ I, Brandon N. Hatfield LPC, do hereby attest that the content above has been, to the best of my ability, been accurately collected and is complete. By acknowledging this statement and saving this document digitally I am also agreeing to treat this digital signature to have the same legal significance I would if I were physically signing this document.

Date Submitted: _____ dd / mm / yyyy **Timestamp:** _____