**Behavioral Health ALF Intake Form**

**Client’s Name:** Click or tap here to enter text.

**Date:** Click or tap here to enter text.

**Referral Source:** Click or tap here to enter text.

**Screening Completed by:** Click or tap here to enter text.

**Client’s Previous Mental Health History**

Has client been in previous mental health treatment before?

☐Yes

Program Name: Click or tap here to enter text.

Contact Information: Click or tap here to enter text.

☐No

Why were services discontinued? Click or tap here to enter text.

Were there any therapies that you found especially helpful? Click or tap here to enter text.

What coping skills do you have, that help you, when you start to decompensate? Click or tap here to enter text.

What interventions do not help you? Click or tap here to enter text.

**Hospitalization History (last 5 years)**

Hospital: Click or tap here to enter text.

Date Month/Year: Click or tap here to enter text.

Duration: Click or tap here to enter text.

Psychiatric/Somatic: Click or tap here to enter text.

Hospital: Click or tap here to enter text.

Date Month/Year: Click or tap here to enter text.

Duration: Click or tap here to enter text.

Psychiatric/Somatic: Click or tap here to enter text.

Hospital: Click or tap here to enter text.

Date Month/Year: Click or tap here to enter text.

Duration: Click or tap here to enter text.

Psychiatric/Somatic: Click or tap here to enter text.

**Psychiatric Symptoms/Risk Behaviors**

Why are you seeking this placement? Click or tap here to enter text.

Current Primary Psychiatric Symptoms: Click or tap here to enter text.

Describe Symptoms/Risk Behaviors

|  |  |  |  |
| --- | --- | --- | --- |
| **Symptom/Risk Behavior**  | **Past Behavior or Currently Experiencing?**  | **Description of Behavior**  | **Severity**  |
| Auditory Hallucinations  |   |   |   |
| Visual Hallucinations  |   |   |   |
| Delusional Thoughts  |   |   |   |
| Paranoia  |   |   |   |
| Depression  |   |   |   |
| Mood Swings  |   |   |   |
| Isolation/Withdrawal  |   |   |   |
| Confusion/Memory Problems  |   |   |   |
| Wandering  |   |   |   |
| Anger Outbursts/Rages  |   |   |   |
| Impulsivity  |   |   |   |
| Obsessive Behaviors  |   |   |   |
| Sleep Disorder  |   |   |   |
| Anxiety/ Panic Attacks  |   |   |   |
| Self-Injurious Behaviors  |   |   |   |
| Suicidal Ideations/Attempts  |   |   |   |
| Homicidal Ideations/Attempts  |   |   |   |
| Medication Non- Adherence  |   |   |   |

When do you experience stress?: Click or tap here to enter text.

How do you cope with stress?: Click or tap here to enter text.

Can you describe any symptoms or behaviors that indicate that you may be experiencing a relapse of your illness?: Click or tap here to enter text.

**Somatic Issues and Symptoms:**

Date of your last physical exam?: Click or tap here to enter text.

Date of last TB Test?: Click or tap here to enter text.

Results: Click or tap here to enter text.

Describe any vision problems: Click or tap here to enter text.

Describe any hearing impairment: Click or tap here to enter text.

Describe any speech impairment: Click or tap here to enter text.

Do you have an Advance Directive? Click or tap here to enter text.

☐Yes

Do you have a copy:

☐No

Do you have a Psychiatric Advance Directive?

☐Yes

Do you have a copy: Click or tap here to enter text.

☐No

Are interested in developing one? Click or tap here to enter text.

Do you have a Wellness and Recovery Action Plan (WRAP)?

          ☐ Yes

Do you have a copy: Click or tap here to enter text.

☐No

Are interested in developing one?: Click or tap here to enter text.

Do you have trouble with the following Activities of Daily Living? If so, explain

☐Eating: Click or tap here to enter text.

☐Bathing: Click or tap here to enter text.

☐Hygiene: Click or tap here to enter text.

☐Clothing/Grooming: Click or tap here to enter text.

☐Mobility: Click or tap here to enter text.

**Substance Use Assessment:**

Have you ever used Alcohol

☐Yes

How many days a week?: Click or tap here to enter text.

☐No

Have you ever used illegal substances?

☐Yes

What substance(s): Click or tap here to enter text.

☐No

Have you ever used or are you currently using Pain Management medication?

☐Yes

What clinic? Click or tap here to enter text.

How long have you been attending/were attending? Click or tap here to enter text.

☐No

Are you currently connected to substance use treatment?

☐Yes

Name of Substance Use Treatment Provider? Click or tap here to enter text.

Contact Information: Click or tap here to enter text.

☐No

**CAGE Assessment**

CAGE Questionnaire - Screen for Alcoholism (ADULT)

This questionnaire will only be scored correctly if you answer each question. Please check the one response to each item best describes how you

have felt and behaved over your whole life.

(Score of 2 or more yes responses are clinically significant for at risk problem drinking.)

1. Have you ever felt you should cut down on your drinking?

☐Yes

☐No

1. Have people annoyed you by criticizing your drinking?

☐Yes

☐No

1. Have you ever felt bad or guilty about your drinking?

☐Yes

☐No

1. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover

☐Yes

☐No

Score: # of yes responses:

**Please continue screening assessment (forms attached):**

**☐**TBI Screen

☐PHQ-9

**Psychosocial Assessment**

Significant events, stressors, and factors:

Were you the victim of physical, sexual, mental, or financial abuse as a child and/or an adult?:

If you don’t mind sharing, how long did you experience the abuse?

Were the individual(s) arrested and/or prosecuted?

Have you ever been apart of a natural disaster?:

Were you ever in a car accident? Click or tap here to enter text.

Did you have to go to the hospital for care? Click or tap here to enter text.

Did you ever experience community violence (e.g. shootings, robbery, burglary, bullying, assault)?: Click or tap here to enter text.

Did you experience the death of a loved one and/or close friend?: Click or tap here to enter text.

Did you experience a major surgery, that caused you anxiety?: Click or tap here to enter text.

Did you ever experience a life threatening illness?: Click or tap here to enter text.

Have you ever been in a state hospital?: Click or tap here to enter text.

Did you experience inpatient hospitalization as a child?: Click or tap here to enter text.

What age(s): Click or tap here to enter text.

Have you ever been arrested?: Click or tap here to enter text.

Have you ever served any jail or prison time?: Click or tap here to enter text.

Did you experience any trauma in your childhood (e.g. poverty, parental incarceration, domestic violence, substance use)?: Click or tap here to enter text.

Have you been a victim of domestic violence?: Click or tap here to enter text.

Did you ever experience separation from a parent or caregiver?: Click or tap here to enter text.

Have you ever experienced war or terrorism?: Click or tap here to enter text.

Have you ever been a victim of human trafficking?: Click or tap here to enter text.

Have you ever witnessed a traumatic event?: Click or tap here to enter text.

Are you aware of any family members, that are living with a mental health disorder?:

**Education and work history**

What was the highest level of education you completed?: Click or tap here to enter text.

Did you have any difficulty in school? Click or tap here to enter text.

Have you ever worked?

☐Yes

Where did you work?: Click or tap here to enter text.

How long did you work?: Click or tap here to enter text.

☐No

List Identified Support System

|  |  |  |  |
| --- | --- | --- | --- |
| Contact Name  | Relationship to client  | How active/involved are they in your life?  | Phone Number  |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |

**Behavioral Health Assisted Living Intake Interview and Recovery Goals**

What are your long term goals?:  Click or tap here to enter text.

What are your strengths/talents?: Click or tap here to enter text.

What obstacles do you feel that you need to overcome to reach your goals? (Psychiatric Symptoms, medical issues, limited skills, etc): Click or tap here to enter text.

What are your personal expectations?: Click or tap here to enter text.

What is your hope for your personal recovery and resiliency?: Click or tap here to enter text.

What symptoms/behaviors do you typically show when you first get sick/decompensate?: Click or tap here to enter text.

Do you currently have people in your life who are supportive? If so, who?

Do you have any hobbies?: Click or tap here to enter text.

**Insights:** Click or tap here to enter text.

**What services do you feel that you need?:** Click or tap here to enter text.

**Is there anything else you would like me to know?**: Click or tap here to enter text.

Staff Signature: Click or tap here to enter text.

Title: Click or tap here to enter text.

Date: Click or tap here to enter text.