

NSMH CBCM Intake Assessment Form



Date: _____

NEW

UPDATE

DEMOGRAPHICS

Client Name: _____ SSN _____

D.O.B/ Age: _____ / _____ AMHD REF# _____

Home Address: _____ City: _____ Zip Code: _____

Phone: _____ (H) _____ (cell) _____ (other)

CONTACTS & SUPPORT SYSTEM

Contact Name: i.e. Family, PO's, PD, DHS, PCP, Psychiatry	Relationship (describe)	Phone:	Fax:	Address/ unit/clinic:
1.	Emergency Cont.			
2.	DHS:			
3.	Psychiatrist			
4.	PCP			
5.	Psychologist Counselor			
6.	PO			
7..	Public Defender			
8.	Judge			
9.	MedQuest			
10. If you are incapacitated or unable to make decisions for yourself who would you like to designate as your RESPONSIBLE PARTY ?				
NAME:		ADDRESS/PHONE		

FAMILY/ HOUSEHOLD/SUPPORT COMPOSITION

HOMELESS
 NEEDS HOUSING
 LIVES ALONE

NAME	AGE	RELATIONSHIP	OCCUPATION	IS THIS A SUPPORT PERSON

ALLERGIES: None

Medications:		Food:	
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Client Name: _____

CURRENT DIAGNOSIS:

Code:	Dx:	Signs & Symptoms:
Axis I:		
Axis II;		
Axis III:		
Axis IV:		
Axis V:	GAF=	

CURRENT PRESCRIPTION LISTING: None at Intake

Mental Health Dx	Medication(s):	Dosage:	Frequency:	Doctor
Medical Health Dx	Medication(s):	Dosage:	Frequency:	Doctor

Medication consistency: _____

Side Effects: _____

Fears/Concerns: _____

Special Needs Identified by Consumer: _____

Client Name: _____

PAST (Psychiatric) HISTORY

Date of Diagnosis:	What event lead to the diagnosis, what was the outcome:

PAST (Psychiatric) MEDICATIONS (If known)

Medication Name	Purpose: depression, schizophrenia	Reason for D/C or why it was stopped

CHILDHOOD HISTORY (Consumers Perception)

Consumer states:

HOSPITALIZATION HISTORY None

Hospital (circle)	Date(s):	Reason i.e. psychiatric, medical, surgery
Q C K O: (describe)		
Q C K O:		
Q C K O:		
Q C K O:		

Serious or Frequent illness(s): _____

Client Name: _____

LETHALITY HISTORY

None

Suicide Attempt Date(s):	Method	Outcome or Treatment
1.		
Describe how you tried to harm yourself:		
2.		
Describe how you tried to harm yourself:		
3.		
Describe how you tried to harm yourself:		
Suicidal Ideation (describe):		(If client experiences SI, please address on Crisis Plan & MRP)

Homicidal Attempt Date(s):	Method	Outcome or Treatment
1.		
Describe how you tried to harm someone else:		
2.		
Describe how you tried to harm someone else:		
3.		
Describe how you tried to harm someone else:		
Homicidal Ideation (describe):		(If client experiences HI, please address on Crisis Plan & MRP)

Lethality Concerns: _____

Stressors/ triggers: _____

Current or Past Maladaptive Responses to Triggers/ Stressors: i.e. OD, drug use, aggression, depression, isolation.

Healthy options to manage or respond to stressors and Triggers: i.e. calling someone, exercise, music, medication,

Client Name: _____

LEGAL HX None

(If client has legal encumbrances, please address on MRP)

Charge:	Incarceration/ Facility	Dates:	Status (parole, probation, CR):

SUBSTANCE ABUSE/ USE HISTORY: No substance abuse/ use hx.

Substance:	Last Used:	Notes: frequency, seeking Tx?,	(If client has a Hx of SA please address on MRP)
Nicotine:			
Alcohol:			
Marijuana:			
Ice:			
Cocaine:			
Crack:			
Heroin:			

Current or Past Drug Treatment Programs: _____

Outcomes of Programs: _____

Client Name: _____

HEALTH INSURANCE No insurance at intake.

(If NONE please address on MRP ie. Apply for benefits)			
Provider:	Policy #	Effective date (if known)	Notes:
Medicaid			
Evercare			
Ohana			
MediCare			
MedQuest: Kaiser			
HMSAQuest			
Aloha Care			
TRI-CARE			
VA			
Private (specify)			
Other (specify)			

HOUSEHOLD INCOME & ASSISTANCE: No income at intake.

Type:	Person Receiving Income:	Monthly Amount:	Total
(If no income please address on MRP ie. Apply for benefits)			
SSI	1.	1.	
	2.	2.	
SSDI	1.	1.	
	2.	2.	
Financial (Welfare)	1.	1.	
	2.	2.	
Food Stamps	1.	1.	
	2.	2.	
Employment	1.	1.	
	2.	2.	
Other	1.	1.	
	2.	2.	

Client Name: _____

EXPENSES / DEBTS: No expense / debt at intake.

Type:	Monthly Amount:	Accrued Debt ?	Notes: (address or decline on MRP)
Rent:			
Electricity:			
Phone:			
Cable			
Food			
Other (describe)			

EMPLOYMENT & EDUCATIONAL HISTORY

Is consumer CURRENTLY employed? Y N		Does the consumer wish to seek employment? Y N (If yes please address on MRP)	
EMPLOYER name/ address Most recent first	POSITION	DATES	REASON FOR LEAVING
Employment Resources Available to Consumer (list):			
Is consumer CURRENTLY a student? Y N		Does the consumer wish to attend school? Y N (If yes please address on MRP)	
Educational Experience/Hx:	SCHOOL	DATES	GRADUATE/COMPLETE
Educational Resources Available to Consumer (list):			

PSYCHOSOCIAL EXPERIENCE & PREFERENCES

Are you ACTIVELY INVOLVED with or want the following addressed within your Treatment and Recovery? (If yes please address on MRP)		
Cultural Identity (Ethnic self identity)		Y N
Spiritual Identity (Religion)		Y N
Leisure/Recreation/Hobbies: (Enjoy doing)		Y N
Strengths (consumers perception) (skills, health, etc.)		
Improvements Needed: (consumers perception)		

