Different Like Me

New Client Intake Form and Assessment

Date: _____

Name_____ DOB:_____

Gender at Birth: ☐ M ☐ F Gender Identity: _____

Address:_____

City _____ State _____ Zip _____

Home Phone # _____ Cell # _____ Work # _____

Person Completing Form (if not client): _____Relationship: _____

Primary Care Physician: _____ Phone: _____

Current Mental Health Diagnoses (if any) and length of diagnosis:

_____

Emergency Contact:

Name: _____Relationship: _____Phone #: _____

Referred by:

Name of person/organization: _____ Phone: _____

Reason for Visit:

Symptoms, behaviors, stressors that are concerning you: _____

_____

_____

_____

_____

_____

Previous Mental Health Treatment:

☐ I have <u>never</u> had other mental health treatment

☐ I <u>have had</u> other mental health treatment

Reason for Treatment/Diagnosis: _____

Dates Treated: _____ Provider: _____

Medical History:

Please check off any current or prior conditions

Neurologic

- ☐ Aphasia (Speech or Language Disorder)
- ☐ Brain Injury
- ☐ Concussion(s)
- ☐ Cerebral aneurysm
- ☐ Coma
- ☐ Loss of consciousness
- ☐ Confusion
- ☐ Coordination problems
- ☐ Dizziness
- ☐ Encephalitis
- ☐ Epilepsy or seizure
- ☐ Fainting (Syncope)
- ☐ Room spinning (Vertigo)
- ☐ Headaches
- ☐ Hypoxia (loss of oxygen to the brain)
- ☐ Infection of brain
- ☐ Intellectual or Developmental Disability
- ☐ Meningitis
- ☐ Muscle control or movement problem
- ☐ Numbness
- ☐ Tingling sensation
- ☐ Paralysis
- ☐ Spinal Cord Injury
- ☐ Stroke (CVA, cerebral hemorrhage)
- ☐ Transient Ischemic Attack (TIA)
- ☐ Tumor of brain
- ☐ Tumor of spinal cord

Cardio-vascular

- ☐ Abnormal heart rhythm
- ☐ Bleeding or bruising easily
- ☐ Blood vessel disease (carotid stenosis, arteriosclerosis)
- ☐ Blood disorder (anemia, hemophilia, sickle cell, etc.)
- ☐ Heart attack
- ☐ Congestive Heart Failure
- ☐ CAD
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ High cholesterol
- ☐ High triglycerides
- ☐ Peripheral vascular disease

Gastro-intestinal

- ☐ Bowel incontinence
- ☐ Change in bowel habits or stool
- ☐ Irritable bowel syndrome
- ☐ Liver disease
- ☐ Malnutrition
- ☐ Dehydration
- ☐ Stomach pain or digestive problem

Genital-urinary

- ☐ Bladder Incontinence
- ☐ More frequent urination
- ☐ Kidney disorder
- ☐ Prostate disorder
- ☐ Reproductive disorder
- ☐ Sexual organ abnormality
- ☐ Sexual functioning disorder
- ☐ Urinary Tract Infection (current or frequent)

Muscular-skeletal

- ☐ Amputation
- ☐ Arthritis
- ☐ Degenerative joint disease
- ☐ Joint abnormality
- ☐ Falls (frequent or unexplained)
- ☐ Fracture (current or recent)
- ☐ Muscle tic
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Polio
- ☐ Post-polio syndrome
- ☐ Weakness

Dermatology

- ☐ Rash, discoloration, itch, swelling, tenderness, lump

Genetic Disorder

- ☐ Specify:

Metabolic Disorder

- ☐ Specify:

Cancer

- ☐ Describe type:

  Treatments:
  - ☐ Chemo
  - ☐ Radiation
  - ☐ Surgery

Rheumatology

- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ Lupus

Eyeglasses:

- ☐ Reading
- ☐ Distance

Hearing aid:

- ☐ Left ear
- ☐ Right ear

Ambulation:

- ☐ Wheelchair
- ☐ Cane
- ☐ Walker Prosthesis

Head, Ears, Eyes, Nose, Throat

- ☐ Abnormality of head, ears, eyes, nose or throat
- ☐ Ear infections (severe or frequent when young)
- ☐ Inner ear disorder
- ☐ Loss of hearing
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Eye movement or eye tracking problem
- ☐ Vision change
- ☐ Change in ability to smell
- ☐ Cough (chronic or severe)
- ☐ Neck stiffness, pain or lump
- ☐ Swallowing difficulty

Respiratory

- ☐ Asbestosis
- ☐ Asthma
- ☐ Breathing problems or shortness of breath
- ☐ Chronic Obstructive Pulmonary Disease (COPD)

Endocrine

- ☐ Diabetes Insulin-dependent
- ☐ Diabetes Non-insulin dep.
- ☐ Hypoglycemia
- ☐ Pituitary disorder
- ☐ Hypothyroid
- ☐ Hyperthyroid

Infection

- ☐ AIDS
  - ☐ HIV+
- ☐ Infection:
  - ☐ Fungal
  - ☐ Lyme
  - ☐ Parasitic
- ☐ Sexually transmitted disease

Sleep

- ☐ Difficulty falling asleep
- ☐ Middle of night awakenings
- ☐ Excessive sleep or daytime napping
- ☐ Unpleasant leg movements at night
- ☐ Acts out dreams at night
- ☐ Narcolepsy or sleep attacks during day
- ☐ Sleep apnea
- ☐ Severe snoring, disrupted breathing

Mental Health

- ☐ Addiction
- ☐ Anxiety disorder
- ☐ Attention-Deficit/Hyperactivity
- ☐ Autism, Asperger's or PDD
- ☐ Bipolar disorder (Manic-depression)
- ☐ Depression
- ☐ Eating disorder
- ☐ Hallucinations
- ☐ Obsessive-compulsive behaviors
- ☐ Personality disorder
- ☐ Phobia
- ☐ Physical neglect History
- ☐ Posttraumatic Stress Disorder Trauma exposure
- ☐ Schizophrenia
- ☐ Sexually abused
- ☐ Other physical abuse

Other / Constitutional

- ☐ Autoimmune disease
- ☐ Birth or congenital defect
- ☐ Birth Injury
- ☐ Chronic fatigue
- ☐ Chronic pain
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Dietary restrictions or problems with certain foods
- ☐ Driving concerns (accidents, unsafe driving)
- ☐ Fever / Chills / Sweats
- ☐ Loss of appetite
- ☐ Nausea or vomiting
- ☐ Recent fever or infection
- ☐ Sex/gender change
- ☐ Thirst (excessive)
- ☐ Toxic substance exposure
- ☐ Transgender
- ☐ Large weight gain
- ☐ Weight loss
- ☐ Appetite change

Activities of Daily Living (check any problems)

- ☐ Self-care (hygiene, dressing, healthcare, toileting)
- ☐ Feeding self / Eating /Meal management / Nutrition
- ☐ Safety Awareness
- ☐ Housework (laundry, cleaning home, washing dishes)
- ☐ Financial management
- ☐ Shopping, making appropriate purchases
- ☐ Medication management
- ☐ Community and social involvement
- ☐ **Patient had a trip outside the country in past 3 months**

Explain anything checked off above: _____

_____

_____

_____

Allergies/Reactions: _____

Surgical History: _____

Other Hospitalizations: _____

Current List of Medications

Name (prescription, over-the-counter, herbal)	Dose	Times per day	Condition used for	Date Started	Side Effects
1.					
2.					
3.					
4.					
5.					
6.					

Substance Use History

Type	Date of Last Use	Amount of Last Use	Frequency/ Amount of Use	Age of First Use	Never Used
Nicotine					☐
Caffeine					☐
Alcohol					☐
Marijuana					☐
Amphetamines					☐
Hallucinogens					☐
Cocaine/Crack					☐
Heroin					☐
Prescription Meds					☐
Other:					☐

Treatment/Recovery History (if any): _____

_____

_____

Childhood Issues *(check any that apply)*

- ☐ Development (problems developing, walking, talking or motor skills)
- ☐ Temperament (over or underactive, withdrawn, not social, negative mood)
- ☐ Health (significant childhood medical problems)
- ☐ Placement (as a child, the client was adopted, in foster care, or institutionalized)
- ☐ Trauma (there was childhood abuse, neglect, or trauma)

Comments: _____

_____

Were there any complications during pregnancy/birth of the client? _____

_____

_____

Educational History:

Highest Level of Education: _____

Did the client have any learning/emotional/behavioral issues in school? (if yes, please explain) _____

_____

_____

Current Employment:

- ☐ Unemployed
- ☐ Retired date: _____
- ☐ Unable to work
  Explain: _____
- ☐ Student
- ☐ Currently Employed
  - ☐ Full-time
  - ☐ Part-time

Occupation/Job Title: _____

Employer: _____ Length of Time in Job: _____

Military Service:

☐ None ☐ Serving Now ☐ Served in Past

Branch: _____ Rank: _____ Years Served: _____

Injuries while serving: _____

Family:

Mother's Name: _____ Age: _____ Deceased: Y N

Father's Name: _____ Age: _____ Deceased: Y N

Briefly Describe Relationship with Parents: _____

_____

_____

Siblings

	Name	Age	Deceased	Full, ½, Step
1.	_____	_____	Y N	_____
2.	_____	_____	Y N	_____
3.	_____	_____	Y N	_____
4.	_____	_____	Y N	_____

Briefly Describe Relationship with Siblings: _____

_____

_____

Children

	Name	Age	Biological, Adopted, Step, etc.
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Briefly Describe Relationship with Children: _____

_____

_____

Relationship Status

☐ Single
☐ Married now
  ☐ Years Married: _____
  ☐ Times Married: _____
☐ Separated
☐ Divorced
☐ Widowed
☐ Lives with Partner (unmarried)

Spouse/Partner's Name: _____ Age: _____

Occupation: _____ Length of Relationship: _____

Do you live with your partner? Y N

Living Arrangement:

Client lives in a(n):

- ☐ House
- ☐ Apartment
- ☐ Retirement Community
- ☐ Assisted Living
- ☐ Nursing Home
- ☐ Group Home
- ☐ Institutional Setting
- ☐ Other:

List Everyone the Client Lives With:

	Name	Age	Relationship to Client
1.			
2.			
3.			
4.			

Any comments on living situation: _____

_____

_____

Community/ Support *(circle yes or no)*

Y N Do you have friends in whom you can confide?

Y N Do you have pets?

Y N Are you actively involved in a spiritual practice?

If yes, please explain _____

Y N Are you actively involved in any other community activities?

If yes, please explain _____

Y N Do you have any hobbies?

If yes, please explain _____

Y N Do you feel comfortable talking to someone if you feel sad, anxious, or depressed?

If yes, please explain _____

Y N Is there anything else you would like to tell us about your community or support system?

If yes, please explain _____

Sexuality/ Sexual Orientation

Please describe your sexuality as you define it _____

_____

Please describe your gender as you define it _____

_____

Are you having any difficulty understanding/accepting your sexuality and gender? _____

_____

Race/ Culture

Race or Ethnicity _____ Country of birth _____

Languages Spoken _____ Religion _____

Are you facing any difficulties regarding race or culture? (if yes, please explain) _____

_____

_____

Client Checklist

Check All That Apply

- ☐ Homicidal/Assaultive
- ☐ Suicidal/Self-Harm
- ☐ Access to Weapons
- ☐ Trauma
- ☐ Neglect/Abuse
- ☐ Domestic Violence
- ☐ Legal Issues
- ☐ Crime/Gang Involvement
- ☐ Runaway
- ☐ Inappropriate/Risky Sexual Behavior
- ☐ Substance Use/Abuse
- ☐ Cognitive Impairment
- ☐ Cultural Isolation
- ☐ Potential for Victimization
- ☐ Risk of Homelessness
- ☐ Unsafe Home Environment
- ☐ Financial Resources at Risk
- ☐ Other:

If checked any of these, briefly explain: _____

_____

_____

_____

Check All That Apply

- ☐ Hopeless about the future
- ☐ Helpless
- ☐ Social Withdrawal
- ☐ Crying a Lot
- ☐ Hallucinations
- ☐ Delusions
- ☐ Panic Attacks
- ☐ Phobias
- ☐ Compulsions
- ☐ Obsessions
- ☐ PTSD
- ☐ Dread
- ☐ Drug Problems
- ☐ Anxiety/Nervousness

Comments:

_____

_____

_____

_____

In the past 4 weeks, have you experienced any of the following? *(check all that apply)*

- ☐ Loss of interest/pleasure in doing things
- ☐ Difficulty sleeping
- ☐ Sleeping too much
- ☐ Feeling tired
- ☐ Trouble concentrating
- ☐ Moving too slowly
- ☐ Fidgeting too much
- ☐ Feeling like a failure to yourself/others
- ☐ Thoughts that you are better off dead
- ☐ Thoughts of hurting yourself
- ☐ Sudden feelings of anxiety or panic
- ☐ Panic attacks
- ☐ Worrying more than usual
- ☐ Becoming easily irritable
- ☐ Being unable to control how much you eat
- ☐ Eating an unusually large amount of food
- ☐ Fasted for more than 24 hours
- ☐ Become extremely concerned about your weight

If checked any of these, briefly explain: _____

_____

_____

_____