TRI-COUNTY MENTAL HEALTH SERVICES, INC.

CLIENT NAME: ______________________________ **DATE OF BIRTH:** ______________
Name of person completing form: ______________________ **and Relationship:** ______________________

Please answer the following as completely as you can for the individual who will receive services. This will assist us in providing the most appropriate care.

Briefly describe why you are seeking services at Tri-County Mental Health Services?

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____
____

CURRENT SYMPTOMS

- ☐ Loss of interest in things I used to enjoy
- ☐ Decreased Appetite
- ☐ Decreased Motivation
- ☐ Sleeping too much
- ☐ Difficulty falling/staying asleep
- ☐ Irritability
- ☐ Low Self-Esteem
- ☐ Poor Concentration
- ☐ Sadness
- ☐ Tiredness
- ☐ Crying spells
- ☐ Withdrawal from others

- ☐ Hopelessness
- ☐ Thoughts of Harming Self
- ☐ Thoughts of Harming Others
- ☐ Self Harm behaviors
- ☐ Aggression towards others

- ☐ Fire Setting
- ☐ Gambling problems
- ☐ Inattention
- ☐ Impulsivity
- ☐ Substance Use
- ☐ Stealing
- ☐ Family Conflict
- ☐ Sexual Problems
- ☐ Anger

- ☐ Anxiety
- ☐ Flashbacks
- ☐ Nightmares
- ☐ Fear or anxiety around others

- ☐ Hearing sounds or voices others don't hear
- ☐ Recurring unwanted thoughts
- ☐ Paranoia
- ☐ Seeing things that others don't see

- ☐ Defiance
- ☐ Toileting problems
- ☐ Hyperactivity
- ☐ School Problems
- ☐ Separation Anxiety
- ☐ Temper Tantrums
- ☐ Aggression towards others
- ☐ Difficulty focusing on school work

- ☐ Chronic Pain
- ☐ Headaches
- ☐ Nausea
- ☐ Rapid Heart Beat
- ☐ Shortness of Breath
- ☐ Slow Heart Beat
- ☐ Stomach Aches
- ☐ Sweating

- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Concerns about my weight
- ☐ Concerns about my appearance
- ☐ Frequent dieting

Any other symptoms not already mentioned: ____

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Do you drink alcohol? ☐ **Yes** ☐ **No**
Have you ever experimented with drugs? ☐ **Yes** ☐ **No**

If you answered yes to either of the above questions, please answer the following questions:

1. Have you felt you should cut down on your drinking or drug use? ☐ Yes ☐ No
2. Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No
3. Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover? ☐ Yes ☐ No

Do you ever gamble? ☐ **Yes** ☐ **No**
If yes, please answer the following questions:

Have you ever felt the need to bet more and more money? ☐ Yes ☐ No
Have you ever had to lie to people important to you about how much money you gamble? ☐ Yes ☐ No
Are you or your family concerned about your gambling? ☐ Yes ☐ No

Do you use tobacco? ☐ **Yes** ☐ **No** If yes, please list how often & type of product: ____________________

TRI-COUNTY MENTAL HEALTH SERVICES, INC.

PERSONAL INFORMATION

Do you have a Religious Preference? ☐ **Yes** ☐ **No**
If yes, please describe: ______________________________

Marital History / Significant Relationships:
☐ Single ☐ Married ☐ Significant Relationship ☐ Separated ☐ Divorced
☐ Widowed ☐ Domestic Partner/Civil Union

Sexual Orientation:
☐ Heterosexual ☐ Homosexual ☐ Bisexual

Are you having difficulty finding or maintaining employment? ☐ **Yes** ☐ **No**
If yes, would you like to be employed? ☐ Yes ☐ No

What do you enjoy doing for recreation?
____
____
____

LEGAL INFORMATION:

Are you currently on probation or parole? ☐ Yes ☐ No
If yes, who is your Probation/Parole Office: ______________________________

Any DUI/DWI Convictions/Minor In Possession of Alcohol and/or Tobacco? ☐ Yes ☐ No

Any time served in penitentiary / jail/Juvenile Detention/DYS Facility? ☐ Yes ☐ No

Any other criminal charges / convictions/juvenile offenses (including status offenses, such as truancy or running away)? ☐ Yes ☐ No

Any court action pending? ☐ Yes ☐ No

HEALTH INFORMATION:

Do you have a primary care physician (PCP) who you see on a regular basis? ☐ Yes ☐ No

Primary Care Physician:	**Phone:**
Address:	

If no, do you know how to access care from a primary care physician? ☐ Yes ☐ No

Are you currently taking any medications? ☐ Yes ☐ No
If yes, please list all:
____
____
____

Who prescribed these medications? ______________________________

CLIENT NAME: ______________________________ **CLIENT ID#:** ______________

TRI-COUNTY MENTAL HEALTH SERVICES, INC.

Do you have any impairments to:

Speech? ☐ Yes ☐ No **Vision?** ☐ Yes ☐ No
Hearing? ☐ Yes ☐ No **Learning ability?** ☐ Yes ☐ No

If yes, please describe: ____
____
____

Are you taking any Over-the-Counter Supplements? ☐ Yes ☐ No
Describe: ____

Do you have any significant medical problem? ☐ Yes ☐ No
Describe: ____

Any significant surgeries: ☐ Yes ☐ No
Describe: ____

Allergies? ☐ Yes ☐ No
Describe: ____

Are you pregnant or attempting pregnancy? ☐ Yes ☐ No ☐ N/A
If yes, have you been receiving prenatal care? ☐ Yes ☐ No ☐ N/A

Have you had a physical exam within the last year? ☐ Yes ☐ No

Have you had a TB Skin test within the last year? ☐ Yes ☐ No

What are your goals for treatment at Tri-County Mental Health Services, Inc.? ____________________
____
____

______________________________________ **Date:** ____________________
Signature of Person Completing this form

12-15-14 CLIN Intake Assessment Clt Version