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?

_____

_____

_____

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: _____

_____

Do you ever drink alcohol? ☐ **Current use** ☐ **Past use** ☐ **Never**

Have you ever used marijuana or other illegal drugs? ☐ **Current use** ☐ **Past use** ☐ **Never**

Do you use tobacco? ☐ **Current use** ☐ **Past use** ☐ **Never**

Have you ever taken more medication than was prescribed or taken prescription medication not prescribed to you? ☐ **Yes** ☐ **No**

PERSONAL INFORMATION

Relationship History:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Domestic partnership/living with partner(s)

☐ Civil Union ☐ Partnered/not living together ☐ Widowed/grieving loss of a partner ☐ Prefer not answer

Sexual Orientation:
☐ Straight ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Queer ☐ Pansexual ☐ Asexual

☐ Unknown ☐ Questioning ☐ Something else (please specify): _____ ☐ Prefer not to answer

What is your current gender identity?

☐ Male ☐ Female ☐ Non-binary ☐ Female-to-Male (FTM)/Transgender Male

☐ Male-to-Female (MTF)/Transgender Female ☐ Genderqueer, neither exclusively male nor female

☐ Prefer not to answer ☐ Other (please specify):_____

HEALTH INFORMATION:

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list all:

_____

_____

_____

Who prescribed these medications? _____

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

Describe: _____

Allergies/Adverse Reactions? ☐ 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

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

_____

_____

_____ **Date:** _____

Signature of Person Completing this form

TRI-COUNTY MENTAL HEALTH SERVICES, INC.
PRE SCREENING FORM

1. Do you use opioids (such as heroin, fentanyl, Oxycontin, Hydrocodone, Percocet, morphine, suboxone, etc.) _____
   _____

2. Do you want medication to assist with your sobriety?
   _____

3. What insurance do you have?
   _____

The Patient Health Questionnaire (PHQ-9)

Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not At All**	**Several Days**	**More Than Half the Days**	**Nearly Every Day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you're a Failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

□ Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficult