Part II: Adult Patient Initial Visit and Screening Information

Instructions:
Please complete this information and bring it back at your next visit.

Patient Information Section

Last Name	First Name	MI	Date of Birth	Soc. Sec. #
			___/___/____	XXX-XX-__ __ __ __

Behavioral Health Screening Section

Please complete the following screening questions; ask your counselor for help if needed.

Section I - Simple Screening Instrument for AOD Abuse (SSI)

Each "Yes" = 3 points, if you answer yes, place a 3 in the line provided.) **Pts.**

1. During the past six months, have you used alcohol or other drugs? .... ☐ Yes ☐ No [___]
   (If "No", GO TO SECTION II; otherwise continue)
2. During the past six months, have you felt that you use too much alcohol or other drugs? .... ☐ Yes ☐ No [___]
3. During the past six months, have you tried to cut down or quit drinking or using drugs? .... ☐ Yes ☐ No [___]
4. Do you feel that you have a drinking or drug problem now? .... ☐ Yes ☐ No [___]

(Further Assessment recommended for a score of 6 and higher) Total Points

Section II - Post Traumatic Stress Disorder Screening (PTSD)

1. Have you witnessed or had a terrible experience that most people never go through, such as a natural disaster, a serious accident, a violent crime, being sexually assaulted or raped, sexually or physically abused, or being in a military war zone or combat?
   ☐ Yes
   ☐ No ***(If "No", SKIP to the next section, SECTION III; otherwise continue)***

(Question 2 – 7) Each "Yes" = 3 points, if you answer yes, place a 3 in the line provided. **Pts.**

2. In the past month have you repeatedly remembered these experiences, even when you did not want to? .... ☐ Yes ☐ No [___]
3. In the past month have you had repeated dreams or nightmares about these experiences?...... ☐ Yes ☐ No [___]
4. In the past month have you thought about these experiences when you did not want to, or been bothered by repeated, disturbing memories, feelings, or dreams? .... ☐ Yes ☐ No [___]
5. In the past month have you tried hard not to think about these experiences, or avoided situations, conversations, people, or feelings that reminded you? .... ☐ Yes ☐ No [___]
6. In the past month have you often felt extremely unsafe, on-guard, watchful when you didn't need to be, or jumpy and easily startled?.. ☐ Yes ☐ No [___]
7. In the past month have you felt emotionally numb (unable to feel most feelings) or detached from your relationships, activities, or surroundings?.. ☐ Yes ☐ No [___]

(Further assessment recommended for a score of 6 and higher) Total Points

Section III - Mental Health Inventory – 5 (MHI-5)

Please check only one box, place the number next to the box you checked in the line provided. ***Pts.***

1. During the past month, how much of the time were you a happy person? [ ]

All of the time	*Most of the time*	*A good bit of the time*	*Some of the time*	*A little of the time*	*None of the time*
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

2. How much of the time during the past month have you felt calm and peaceful? [ ]

All of the time	*Most of the time*	*A good bit of the time*	*Some of the time*	*A little of the time*	*None of the time*
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

3. How much of the time during the past month have you been a very nervous person? [ ]

All of the time	*Most of the time*	*A good bit of the time*	*Some of the time*	*A little of the time*	*None of the time*
☐1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

4. How much of the time during the past month have you felt downhearted and blue? [ ]

All of the time	*Most of the time*	*A good bit of the time*	*Some of the time*	*A little of the time*	*None of the time*
☐1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

5. How much of the time during the past month did you feel so down in the dumps that nothing could cheer you up? [ ]

Always	*Very often*	*Fairly often*	*Sometimes*	*Almost never*	*Never*
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

(Further assessment recommended for a score of *18 and lower)* Total Points

Section IV - Current Problem

Please describe the issue/reason for this visit:

____

____

____

____

____

Section V - Treatment History

1. At **any time in your life, have you been treated** for a substance abuse, psychiatric, psychological, emotional or relationship problems? (For example: taking medications, counseling, hospital, outpatient program, etc - check all that apply)

   ☐ No, **I have never** been involved with treatment before.
   (★ *If* ***"No"****, skip questions 2, 3, 4 and go to the* ***Physical Health Screening Section)***

   ☐ Yes, **in the past** for:(check all that apply)
   ☐ substance abuse, ☐ psychiatric, ☐ psychological or emotional problem, ☐ relationship problems
   I was first treated at age (______)

   ☐ Yes, **currently** receiving treatment for:(check all that apply)
   ☐ substance abuse, ☐ psychiatric, ☐ psychological or emotional problem, ☐ relationship problems

2. What substance abuse and/or psychiatric conditions were you/are you being treated for? (list diagnosis if known)

3. What type of treatment(s) have you participated in (either past or present; check all that apply):

☐ a hospital
☐ a "partial hospital" day program
☐ an intensive outpatient program
☐ a regular outpatient program
☐ weekly individual or group counseling
☐ periodic doctor's office visits for psychiatric medication
☐ treatment in a public agency program (such as MHMR)
☐ other____

4. Have you ever attended 12 step meetings for a substance abuse problem? (check all that apply)

☐ No, I have never attended 12 step meetings
☐ Yes, currently attending
☐ Yes, in the past

Physical Health Screening Section

Do you have now, or have you ever had the following conditions...

1. **Neurological Problems**
Seizures, numbness in limbs, head injury, strokes, other neurological ☐ Yes ☐ No
Comment:

2. **Cardiovascular Problems**
Heart disease, hypertension, heart attack, congestive heart disease, blood clots, other cardiovascular ☐ Yes ☐ No
Comment:

3. **Respiratory Problems**
Pneumonia, chronic cough, positive tuberculosis test, chronic obstructive pulmonary disease, asthma, smoker/former smoker, cancer involving this system ☐ Yes ☐ No
Comment:

4. **Gastrointestinal/Digestive Problems**
Frequent nausea/vomiting, blood in stool/vomit, frequent diarrhea, recent weight loss/gain, liver disease, hepatitis, cirrhosis, alcohol use, cancer involving this system, other gastrointestinal/digestive ☐ Yes ☐ No
Comment:

5. **Kidneys/Urinary Problems**
Kidney disease, dialysis, urinary problems, kidney stones, cancer involving this system, other kidney/urinary ☐ Yes ☐ No
Comment:

6. **Endocrine/Reproductive Problems**
Diabetes, insulin dependent, thyroid problems, cancer involving this system, other endocrine/reproductive ☐ Yes ☐ No
Comment:

7. **Musculoskeletal Problems**
Serious accident, amputations, arthritis, difficulty walking, back injury, other musculoskeletal ☐ Yes ☐ No
Comment:

8. **Skin Problems**
Chronic skin condition, current skin problems, lice - scabies - rash, wounds, other skin problems ☐ Yes ☐ No
Comment:

9. **Dental Problems**
Current dental problems, infections, abscess, chronic pain, needs dentures, other dental problems ☐ Yes ☐ No
Comment:

10. **Allergies**
History of allergies, reactions to medications, other allergic reactions ☐ Yes ☐ No
Comment:

11. **Use of Tobacco Products**
Do you use any tobacco products? ☐ Yes ☐ No ☐ No; I used to, but quit _____ ☐ years *or* ☐ months ago

If "Yes" > > ☐ I smoke tobacco ☐ I "dip" or "chew" tobacco
Use Pattern > > ☐ Several times per day ☐ Almost every day ☐ Several times per month ☐ Occasionally

Other
Within the past 5 years...
History of a disability; short tem or long term ☐ Yes ☐ No
Comment:

Treatment of a chronic (long term) medical condition ☐ Yes ☐ No
Comment:

Overall health rating…
How would you rate your overall health? ☐ Poor ☐ Fair ☐ Average ☐ Above Average ☐ Excellent
Comment:

Medication

A.

List health/mental health disorders that you take medication for:	Medication name (if known)	Describe any side effects of the medication (if any)

B. Any medications prescribed, but not taken and reason (List)?

Patient Signature:		Date:		