

Mental Health Intake Assessment

Date of Service: _____ dd / mm / yyyy

Medical Service Billing Code: 90801 Mental Health Intake Assessment

Completed by: _____ Time In: _____

Time Out: _____ Therapy Style: _____

Identifying Information

Contact Information

Is client insured?

Yes No

Payor Source Info

Primary Email Address: _____ Service Type: _____

Billing / Admin Partner: _____

Mailing Address (if Different)

1(a). Chief Complaint

Use the box below to transfer the presenting circumstances to the client's record in CarePatron.

1(b). Symptom Checklist

- Depressed feelings / sad or down
 - Grief or sadness over recent loss
 - Feelings of guilt
 - Withdrawing from friends or social activities
 - Feelings of anxiety, panic or worry
 - Reduced ability to concentrate / poor attention or focus
 - Feeling overwhelmed or paralyzed

 - Ritualized / repetitive checking behaviors
 - Changes / problems w/ diet & appetite
 - Violent Outbursts / Physical or Verbal lashing out at others
 - Night terrors / other sleep disturbances
 - General relationship problems involving intimate partner or partner(s)
 - Issues related to sexuality / sexual preference / sexual orientation
 - Sexual trauma
 - Increased reliance on drugs or alcohol
 - Experiencing auditory or visual hallucinations

 - Suicidal ideation(s)
 - Other Somatic symptoms
 - Other Psychotic symptoms
 - Other Option not listed
- Feeling tired / low energy / lacking motivation
 - Loss of pleasure
 - Problems getting to sleep / staying asleep
 - Cyclical mood changes (High highs or low lows)
 - Intrusive / Disturbing / Unwanted thoughts
 - Irrational fears or phobias causing distress in daily life
 - Inability to relate to others / develop relationships / connect interpersonally

 - Excessive anger / irritability / agitation
 - Binging and/or Purging behaviors
 - Flashbacks / Preoccupation with painful memory
 - Excessive Hair-pulling or skin picking
 - Relationship problems involving infidelity / broken trust

 - Sexual dysfunction / loss of libido / hypersexuality

 - Problems with gender / gender dysphoria
 - Dissociation - Feeling disconnected from reality

Alcohol & Drugs

Suicidal Ideation (s)

Somatic Sxs

Psychotic Sxs

Other Option not listed

2. Have you been treated for these or related symptoms in the past?

- Yes No

If yes:

3. Is there a known history of mental illness within your immediate family?

Yes No

If yes:

4. Have you experienced any major events that you think might be traumatizing?

Yes No

If yes:

5. Are you currently being treated for any medical condition(s)?

Yes No

If yes:

6. Are any of the conditions mentioned in question 4 chronic?

Yes No N/A (Not applicable)

If yes:

Read the following statement. If true, check the box below and then skip to Section 1.6.

I am not currently prescribed any medications by a doctor or psychiatrist nor am I currently taking any that have been prescribed in the past

7(a). Have you ever been prescribed medication for a mental health condition such as Prozac?

Yes No

If yes:

7(b). Current Medications

Read the following statement. If true, check the box below and then skip to Section 2.2.

I do not currently use drugs or alcohol, nor do I have any history of having used them in the past

8(a).

8(b).

- | | |
|---|---|
| <input type="checkbox"/> Marijuana / THC / Cannabis | <input type="checkbox"/> Tobacco (Cigarettes, Vaping, Chewing Tobacco) |
| <input type="checkbox"/> Alcohol (Beer, Liquor, Hard Ciders) | <input type="checkbox"/> Cocaine / Crack |
| <input type="checkbox"/> Methamphetamine | <input type="checkbox"/> Central Nervous System Depressants (Benzodiazepines) |
| <input type="checkbox"/> Fentanyl | <input type="checkbox"/> Ayahuasca, Mescaline (Peyote) |
| <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> Heroin |
| <input type="checkbox"/> Inhalants | <input type="checkbox"/> Ketamine |
| <input type="checkbox"/> Khat | <input type="checkbox"/> Kratom |
| <input type="checkbox"/> LSD (Acid) | <input type="checkbox"/> MDMA (Ecstasy / Molly) |
| <input type="checkbox"/> GHB | <input type="checkbox"/> Over the Counter Medicines (Dextromethorphan (DXM)) |
| <input type="checkbox"/> Over the Counter Medicine - Loperamide | <input type="checkbox"/> PCP (Angel Dust) |
| <input type="checkbox"/> Prescription Opioids (Oxy/Percs) | <input type="checkbox"/> Prescription Stimulants (Speed) |
| <input type="checkbox"/> Psilocybin (Magic Mushrooms / Shrooms) | <input type="checkbox"/> Rohypnol (Roofies) |
| <input type="checkbox"/> Salvia | <input type="checkbox"/> Steroids (Anabolic) |
| <input type="checkbox"/> Synthetic Cannabinoids (K2/Spice) | <input type="checkbox"/> Synthetic Cathinones (Bath Salts / Flakka) |
| <input type="checkbox"/> Other | |

8(c).

9. Is there a history of drug abuse, alcoholism or any other addiction that runs in your family?

- Yes No

If yes:

10. Has there ever been a time in your life when you thought you ought to cut back on your use

- Yes No

If yes:

11. Are there other areas in your life in which your behaviors could have addictive potential, such as pornography or gambling?

- Yes No

If yes:

12. Do you ever think about suicide or your own death, even if it just a passing thought or fantasy and/or daydream?

- Yes No

If yes:

13. In the past month have you seriously considered taking action to end your life, or have you felt that things would be better off if you were dead?

- Yes No

If yes:

14. Have you ever attempted suicide in the past?

Yes No

If yes:

15. Do you currently wish to use harm or death, directly or indirectly to someone else?

Yes No

If yes:

16. Do you feel threatened or unsafe either at home, at work or at school?

Yes, at home Yes, at work or at school No

If yes:

17(a).

17(b).

18. What are your current living arrangements?

- Private Residence (Apartment, House, Condo)
 - Homeless Shelter
 - Group Home
 - Sober Living Community
- Prison, Jail or Halfway House
 - Student Housing
 - Skilled Nursing Facility
 - None; Homeless
 - Other

More details:

19. With whom do you reside?

- Spouse / Partner(s)
- Roommate(s)
- Parents, In-Laws or Other Family
- Friend(s)
- Children or Step-Children
- Pet(s)
- N/A (I live alone)
- Other

More details:

20. Do you have individuals in your life whom you trust and who you consider to be part of your support system?

- Yes No

If yes:

21. Do you have any involvement in community activities (such as social groups, clubs, churches or associations)?

- Yes No

If yes:

22. Did you graduate high school or did you obtain a GED?

- Yes, Graduated Yes, Obtained GED No

If no:

23. Did you attend any college or Post-Secondary Education?

- Yes No

If yes:

24. Did you earn any diplomas, degrees, certificates, or credentials?

- Yes No

If yes:

25. Were there any intellectual / cognitive impairments, learning disabilities, or other ways that learning was hard?

- Yes No

If yes:

26. Are you currently employed / working?

- Yes, Full-Time Yes, Part-Time No / Unemployed

If yes:

27. Is there a defined industry that you specialize in or a type of work where you have worked the longest?

- Yes No

If yes:

28. Have you ever served in any branch of the military (armed services)?

- Yes No

If yes:

Read the following statement. If true, check the box below & skip to Section 3.7.

- I have no history of arrests or any other legal issues aside from minor traffic violations

29. Have you ever spent any length of time in jail or prison?

- Yes, Jail Yes, Prison No

If yes:

30. Do you have any pending charges, upcoming court cases, outstanding warrants, records that have been sealed by the court or past offenses that have been either expunged or exonerated?

- Yes No

If yes:

31. Do you have any misdemeanors or felonies on your adult record?

- Yes, Felonies Yes, Misdemeanors No

If yes:

32. Does the nature of your offenses require that you register as a sex offender?

- Yes No

If yes:

33. Are you currently on probation, parole, or house arrest?

- Yes, probation
- Yes, parole
- Yes, house arrest
- No, none of the above

If yes:

34. How would you describe your gender identity?

- CIS-gender
- Transgender
- Non-binary
- Other Non-Conforming

If not CIS-gender:

35. By which pronouns do you prefer to be addressed?

- He/Him/His
- She/Her/Hers
- They/Them/Their
- Ze/Hir/Hirs
- Ze/Zir/Zirs
- Xe/Xem/Xyr
- Other

If other:

36. How might you describe your sexual orientation?

- Straight / Heterosexual / Opposite gender loving
- Gay / Lesbian / Homosexual / Same-gender loving
- Bisexual / CIS-gender loving
- Pansexual / All gender loving
- Asexual / Not attracted sexually to others
- Other

If other:

37. Are you currently in a relationship?

- Yes No

If yes:

38. Are you divorced, separated, or widow/widowed to a former spouse?

Yes No

If yes:

39. Do you consider yourself poly (or capable of having a relationship with more than one individual at a time)?

Yes No Don't know / Undecided

If not yes:

40. In how many romantic relationships have you been that you consider to be significant?

5+ 3-4 1-2 None

More details:

41. Do you have any children, whether naturally conceived or conceived with medical assistance; and/or whether involved or uninvolved in their upbringing?

Yes No Don't know / Uncertain

If not no:

42. Which of the following best describe your spiritual beliefs?

- Religious
- New Age
- Atheist
- Agnostic
- Spiritual
- Other

More details:

43. Do you have any recreational interests or hobbies?

Yes No

If yes:

44. Let's talk about your strengths and weaknesses. What are your very best qualities and characteristics? What are good or skilled at doing? As far as challenges go, what are your vulnerabilities, weaknesses, or areas rife for development? Finally, are there any barriers you can foresee that might prevent you from committing to the therapeutic process? List them in the grid below.

45. If any barriers were identified above, have you problem-solved actions that can be made to address them proactively?

Yes No N/A ; No barriers identified

If yes:

4.1(a) Summary

Use the box below to transfer the interpretive summary to the client's permanent record in CarePatron.

4.1(b) Assessment Administered

- PHQ - 9
- GAD - 7
- Sondermind Functional Assessment (if applicable)
- Other (Please clarify)

4.2(a). Diagnosis

ICD-10 Codes

4.2(b). Diagnoses to be Ruled Out / Further Investigated:

4.2(c). Reported / Unconfirmed Historical Diagnos(es)

Goal 1

Goal 2

Goal 3

Goal 4

Use the boxes below to transfer client's stated goals to the client's permanent record in CarePatron.

List recommendations for treatment below.

4.(a). Has an appointment for follow-up been scheduled?

Yes No

If no:

4.(b). Date: _____ dd / mm / yyyy Time?: _____

4.(c). Appointment Type and Location (if applicable).

- Office Location (1100 Spring St. NW Ste 380, Atlanta GA 30308)
- Telehealth Location (Doxy / Sondermind / Sessions / Zoom / Teams) Other

- END of ASSESSMENT -

ATTESTATION

I, Brandon N. Hatfield LPC, do hereby attest that the content above has been, to the best of my ability, been accurately collected and is complete. By acknowledging this statement and saving this document digitally I am also agreeing to treat this digital signature to have the same legal significance I would if I were physically signing this document.

Date Submitted: _____ dd / mm / yyyy Timestamp: _____