BHN INTAKE ASSESSMENT

NAME:				**DATE OF INTAKE:**	
DOB:		**SS #:**		**DOCKET #:**	

INTAKE CLINICIAN:	

PARENT/GUARDIAN NAME:	NA

A. IDENTIFYING INFORMATION, PRESENTING PROBLEMS, PRECIPITATING EVENTS AND/OR MAJOR STRESSORS (include client's own words, reason for referral, history of problem, recent stressors and precipitants):

B. Client's History of Psychiatric Treatment (include current medications)

MENTAL HEALTH	
Diagnosis	
Outpatient Tx (dates)	
Inpatient Tx (dates -length)	
Medications	
Comments:	

C. <u>Client's Current Life Situation</u> (e.g., lives alone, with family, family/foster family functioning, rooming house, group residence, student, employed, social club, psychiatric day treatment, day care, description of support network, leisure interests etc.)

D. History of Abuse or Trauma: Physical ___ Emotional ___ Sexual ___ Other___

E. <u>History</u> (include relevant educational/vocational history, significant life events, history of symptoms and their effect on functioning, family composition, early developmental history, military history, legal/criminal history, religious affiliation.

F. <u>Suicide History</u> (client and family/significant other):
Who, When, # Attempts, Methods, Outcome

G. <u>Legal History</u>

H. <u>Client's History of Violent Behaviors:</u>
Who, When, # Attempts, Methods, Outcome

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I. <u>Substance Use/Abuse and Addictive Behavior History – Current and Past</u> (include information about: context of use, current and past treatment, degree to which client and/or others see it as a problem, peer use).

	1	2	3	4
Substance/ Behaviors				
Age of 1st use				
Last use				
Amount				
Frequency				

Previous substance abuse treatment	
Outpatient Treatment (dates)	
Inpatient Treatment (dates – length of stay)	
Comment	

J. <u>Family History and Social Functioning:</u> (includes family history of physical/mental illness, abuse history, addiction history and treatment)

K. <u>Relevant Medical History</u> (include status of current medical care and current medical condition/medications)

L. MENTAL STATUS NARRATIVE

M. Do either cognitive functioning or learning impairments affect diagnosis or treatment plan: No ☐ Yes ☐ If so, explain:

N. CLINICAL IMPRESSIONS AND TREATMENT RECOMMENDATIONS: (Include any special treatment considerations)

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Clinician: _____

Jeanette Walker, Case Manager

***CLIENT PERCEPTION* OF STRENGTHS/SKILLS:**

Problem		**Objectives**	**Interventions/Modalities**
1.			
2.			
3.			

DIAGNOSIS	
Axis I:	
Axis II:	No Diagnosis
Axis III:	
Axis IV:	
Axis V:	Current GAF -

Length of Stay and Discharge Criteria: