Client Name_____

Arrow Counseling Services, LLC

ADULT AND ADOLESCENT (14 YRS OLD AND OLDER) INTAKE ASSESSMENT

Please complete this form before your first appointment. *All information contained herein is confidential in accordance with the attached policies and procedures and in accordance with the HIPAA Privacy Act. This information is requested to obtain the best level of treatment and care possible.*

Name: _____

Address: _____ Date of Birth _____

_____ Gender: Male Female (Circle One)

SS#: _____ Age:_____

How would you like us to contact you? (Please circle response)

Home:	yes or no	Phone:
Work:	yes or no	Phone:
Cell phone:	yes or no	Phone:
Email:	yes or no	Email address:
Other:		

Name of person completing form: _____

Relationship to person receiving services: _____

In case of an emergency during a therapy session if I become unable to communicate or need non medical assistance, the person I authorize you to contact is located on the Intake Form.

Name: _____

Contact Phone: _____

Special Needs

1. Do you have a need for Assistive Technology (interpreter, verbal instructions, etc.) in the Provision of Services? Yes No
   If yes, Describe:_____
   _____
2. Do you have any other disabilities, disorders or concerns in the area of Special Needs ? Yes No
   If yes, Describe:__ _____
   _____

Current Presenting Issue/Concern

1. Presenting Problem/ Chief Complaint (include impact on social, work, and/or academic functioning):

_____

_____

_____

Client Name_____

2. Please check any of the following problems that you currently are or recently have experienced:

☐ Stress	☐ Marital Problems	☐ Compulsive Behaviors	☐ Anxiety
☐ Other relational problems	☐ Hallucinations	☐ Panic Attacks	☐ Physical Abuse
☐ Sexual Abuse	☐ Depression	☐ Emotional Abuse	☐ Racing thoughts
☐ Alcohol Use	☐ Verbal Abuse	☐ Eating problems	☐ Sexual Problems
☐ Work stress	☐ Drug use	☐ Gender Identity Issues	☐ Pregnancy
☐ Chronic pain	☐ Trouble sleeping	☐ Abortion	☐ Career choices
☐ Financial problems	☐ Anger	☐ Recent death	☐ Controlling
☐ Obsessive thoughts	☐ Legal matters	☐ Fears	☐ Spiritual problems
☐ Parenting problems	☐ Grief	☐ Controlled by others	☐ Other: _____

3. Please indicate the severity of the symptoms you are experiencing:

Symptoms Experienced in the last **two (2) weeks**	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	If longer than 2 weeks please indicate the # of weeks, months, years
Aggression toward others						_____ W, M, Y
Anger Outbursts						_____ W, M, Y
Anxiety						_____ W, M, Y
Attention-Deficit						_____ W, M, Y
Avoidant behaviors						_____ W, M, Y
Can't be alone						_____ W, M, Y
Binging						_____ W, M, Y
Compulsive Behaviors						_____ W, M, Y
Crying						_____ W, M, Y
Disruptive Behavior						_____ W, M, Y
Drug or Alcohol Use						_____ W, M, Y
Enuresis/ Encopresis						_____ W, M, Y
Fear of crowds						_____ W, M, Y
Fear of leaving home						_____ W, M, Y
Feeling Empty						_____ W, M, Y
Feeling worthless						_____ W, M, Y
Financial Problems						_____ W, M, Y
Fire setting						_____ W, M, Y
Flashbacks						_____ W, M, Y
Gambling						_____ W, M, Y
Grandiose Thoughts of self						_____ W, M, Y
Hallucinations						_____ W, M, Y
Headaches						_____ W, M, Y
Hearing Voices						_____ W, M, Y
Hoarding						_____ W, M, Y
Homicidal Ideation						_____ W, M, Y
Hurts animals						_____ W, M, Y
Hyperactivity						_____ W, M, Y
Impulse Control						_____ W, M, Y

Client Name_____

Indecisiveness						_____ W, M, Y
Infidelity						_____ W, M, Y
Irritable						_____ W, M, Y
Isolated						_____ W, M, Y
Lack of eating						_____ W, M, Y
Lack of pleasure in doing things						_____ W, M, Y
Lack of Trust						_____ W, M, Y
Legal Issues						_____ W, M, Y
Lonely						_____ W, M, Y
Lying						_____ W, M, Y
Manipulative						_____ W, M, Y
Memory loss						_____ W, M, Y
Mood swings						_____ W, M, Y
Nightmares						_____ W, M, Y
Obsessive Thoughts						_____ W, M, Y
Oppositional Defiant						_____ W, M, Y
Out of body experiences						_____ W, M, Y
Overeating						_____ W, M, Y
Panic Attacks						_____ W, M, Y
Physical fights						_____ W, M, Y
Physical pain						_____ W, M, Y
Poor concentration						_____ W, M, Y
Poor Self Esteem						_____ W, M, Y
Poor sleep						_____ W, M, Y
Pornography						_____ W, M, Y
Post Partum Depression						_____ W, M, Y
Purging Food						_____ W, M, Y
Racing Heart						_____ W, M, Y
Relationship Issues						_____ W, M, Y
Restricting Food						_____ W, M, Y
Risk Taking						_____ W, M, Y
Sad						_____ W, M, Y
Self-Harm Behaviors						_____ W, M, Y
Sexual Dysfunction						_____ W, M, Y
Sexual Identity Confusion						_____ W, M, Y
Sexually Promiscuous						_____ W, M, Y
Sleep Disturbance						_____ W, M, Y
Spiritual Confusion						_____ W, M, Y
Suicidal Ideation						_____ W, M, Y
Suspicious of others						_____ W, M, Y
Uncontrolled spending						_____ W, M, Y
Unwanted memories						_____ W, M, Y
Verbal fights						_____ W, M, Y
						_____ W, M, Y
						_____ W, M, Y
						_____ W, M, Y

4. Are your problems and/or symptoms affecting any of the following?

☐ Handling everyday tasks	Self esteem	Relationships	Hygiene
☐ Work/School	Housing	Legal matters	Finances
☐ Recreational activities	Sexual activity	Health	

5. Are you motivated or hopeful about treatment, change, and the future? Yes No

Please circle the number that best indicates how motivated you are for change

1 2 3 4 5 6 7 8 9 10

Minimally motivated Moderately motivated Extremely motivated

Current and Past Psychiatric Treatment

1. Are you currently or have you ever been in psychiatric treatment of any type?

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (mental health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-help/Support Groups			

2. Did you have a positive experience in your previous treatment? Yes No

3. Were you compliant with previous treatment? Yes No

4. Any **history** of thoughts/plans/acts/ideation or intention of suicide? Yes No
If yes, circle all that apply: Passive Thoughts Single Attempt Multiple Attempts
If yes, explain: _____
_____

5. Do you **currently** have any thoughts/plans/acts/ideation or intention of suicide? Yes No
If yes, describe: _____
_____

6. Any **history** of thoughts/plans/acts/ideation or intention of homicide? Yes No
If yes, circle all that apply: Passive Thoughts Violence Towards Another
If yes, explain: _____
_____

7. Do you **currently** have any thoughts/plans/acts or intention of homicide? Yes No
If yes, describe: _____

If you answered yes to the above questions, what things happen that make you want to harm yourself or others?
_____
_____

8. Do you feel that you are currently (within the past 6 months) at risk for Dangerous Behaviors?
Yes No
If yes, identify any situation that increases risk for dangerous behaviors: _____
_____
_____

If yes, how do you currently cope or deal with these risks? _____
_____
_____

If yes, describe any warning signs related to the risks of dangerous behaviors:_____
_____

MEDICAL INFORMATION

1. Do you take any medications for any reason? Yes No

2. Have you always taken your medications as prescribed in the past? Yes No

Medication: Please list all medications including prescribed, over the counter and homeopathic.

Name	Dosage	Frequency	Prescribed By	Reason for prescription

Medical Providers:

3. Please list all Health Care Providers: May we contact them to coordinate care?

	Name	**Phone number**		
Primary Care Physician			Yes	No
Psychiatrist			Yes	No
Caseworker			Yes	No
Case Manager			Yes	No
Other _____			Yes	No

Client Name_____

4. Medical History: *Circle all that apply:*

Breathing Problems	Diabetes	High Blood Pressure	High Cholesterol
Heart Problems	Impaired Ability to Walk	Infectious Disease	Impaired Hearing
Thyroid	Impaired Vision	Liver Problems	MR/DD/LD
Obesity	Seizure Disorder	Ulcer	GI Problems

Other:_____

5. Any concerns regarding medical history: _____
_____

6. Number of pregnancies: ____ Number of Live Births: _____ Birth Control? Yes No

7. Any allergies or special precautions? Yes No Unknown
If yes, *circle all that apply*:
Seasonal Medications Food Latex Animals Other
If yes, specify: _____
_____

8. Do you have any special nursing/medical needs? Yes No
If yes, *circle all that apply*:

Walking	Home Health Monitoring	Nursing Home	Dialysis
Clinic Visits/Injections	Oxygen/Portable Oxygen	Pacemaker	Other

If yes, specify: _____
_____

9. Do you experience limitations due to physical health or disability? Yes No
If yes, *circle all that apply*:
Lifting Not Able to Work Strenuous Activities Other
If yes, explain: _____

10. Height _____ Weight_____ BMI _____
If BMI is outside of Healthy Range, would you like strategies to address this issue? Yes No

SUBSTANCE USE

1. Please check all that apply:

Drugs, Alcohol, or Substances:

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								

Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

DEPENDENCE

2. Do you find yourself using more of your chosen substance? Yes No
3. Do you suffer from withdrawal when you try to quit? Yes No
4. Do you use to excess? Yes No

DOES (OR HAS) YOUR USE:

5. Interfere with your daily life? Yes No
6. Place you in hazardous situations? Yes No
7. Cause you legal problems? Yes No
8. Cause you interpersonal conflict? Yes No

OTHER ADDICTIONS

GAMBLING

9. Any history of gambling? Yes No
   If yes, Describe: _____

SEX

10. Any history of sexual acting out, pornography, sex crimes, legal charges, harmful behaviors, etc.?
    Yes No
    If yes, Describe: _____

FOOD

11. Any history of overeating, restricting, and/or purging food? Yes No
    If yes, Describe: _____

OTHER ADDICTION CONCERNS (internet, video games, social media, shopping, etc.)

12. Please describe: _____
_____
_____

MILITARY HISTORY

1. Have you ever served in the military? Yes No Are you currently serving? Yes No

If yes, what branch? _____

If yes, type of discharge (*Circle*): Honorable Dishonorable General Other N/A

2. If yes, *Circle all that apply:*

Positive Military Experience	Experienced Combat Situations
No Traumatic Experiences	Experienced Traumatic Events
AWOL	Injury/ Disability from Experience

Other comments on the experience, any trauma, etc.:

_____
_____
_____

TRAUMATIC EVENTS

1. Have you ever witnessed Domestic Violence? Yes No
If yes, please explain: _____
_____

2. Any current or past experience of trauma: Yes No

If yes, *circle all that apply*:

Emotional Abuse	Neglect	Physical Abuse
Sexual Abuse	Verbal Abuse	Domestic Violence
Witnessed Domestic Violence	Witnessed Abuse	Other:_____

If yes, describe the above or <u>any other traumatic experience</u>: _____
_____
_____
_____
_____

3. Have you received services for past trauma? Yes No N/A
If no, would you be interested in receiving services? Yes No N/A

Intimate Relationships, Social and Current Living Situation

1. Current marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner
Number of times married: _____
If married (or in a significant relationship) more than once, explain reasons for each divorce or separation: _____
_____

2. Current problems with intimate relationships (spouse, friends, children, etc.)? Yes No
If Yes, please describe _____
_____
_____
_____
_____

3.Please list all persons living with you (including spouse, children- step, adopted or foster, extended family, friends, etc.)

Name	Sex	Birthdate	Relationship To You	Additional Information

4. Are there any issues with your current living situation? Yes No
If yes, please describe_____
_____

FAMILY

1. Please list the following people in your life:

Relationship	Name	Birthdate	Describe him/her (e.g. angry, outgoing, supportive, controlling)
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/partner			
Children			

2. Describe your childhood and adolescence (atmosphere, location, significant events).

Circle all that apply:

Parents Divorced	Parents Separated	Parents Remarried
No Involvement of Biological Parents	Parent(s) Deceased	Raised by Grandparents
Raised by Others	Good/Happy Home	Strict Home
Religious Home	Unfair Home	Abusive Home
Absent Family	Multiple Homes	Other

Explain:_____
_____
_____

3. Are significant issues from childhood impacting current presenting problem? Yes No
If yes, *Circle all that apply:*

Client Name_____

Trust Issues with Current Relationships
Difficulty with Activities of Daily Living
Difficulty with Academic/School Functioning
Intrusive Memories
Ongoing Tense Relationships with Family
Loss of Family with Residual Feelings
Explain: _____
_____
_____

4. How well did your parents/guardians get along with each other? □ Great □ Good □ Fair □ Poor □ Terrible

5. How well did you get along with your parents/guardians? □ Great □ Good □ Fair □ Poor □ Terrible

6. Have any **family members** had a history of Mental Illness: Yes No
If yes, please describe below:

Family Mental Health Problems	Who?	Please Describe
Hyperactivity		
Sexually Abused		
Depression		
Manic Depression		
Suicide		
Anxiety		
Panic Attacks		
Obsessive-Compulsive		
Anger/Abusive		
Schizophrenia		
Eating Disorder		
Alcohol Abuse		
Drug Abuse		
Mental Retardation		

7. Family History of Medical Problems? Yes No

Family Medical Health Problems	Who?	Please Describe
Heart Problems		
Cancer		
Diabetes		
Thyroid		

CULTURAL, GENDER, AND SPIRITUAL CONSIDERATIONS

1. Primary cultural/ethnic group?

□ Caucasian
□ Middle Eastern Culture
□ Eastern Culture
□ Asian Culture
□ Latino
□ Native American
□ African
□ African American
□ Other- _____

3. Primary Sub-culture

□ LGBT
□ Goth
□ Bikers (Motorcycles)
□ Sport- Runners, etc.
□ Law Enforcement
□ Medical Field
□ Other-

4. Any Gender and/or Sexual Orientation Issues? Yes No
If yes, describe issues: _____
_____

5. Primary Religious Affiliation *Circle any that apply:*

□ Christian
□ Jewish
□ Islam
□ Buddhism
□ Agnostic
□ Atheist
□ Other _____
□ Wicca
□ Unitarian Universalist
□ Shaman

6. What are your spiritual beliefs and practices? _____
_____

7. How often are you involved in religious or spiritual practices? *Circle all that apply*
Regular Involvement
Occasional Involvement
Special Celebrations/Holiday Involvement
No Involvement

8. Do you have spiritual strengths? No Yes
Please describe_____

_____

9. Do you have spiritual problems/issues? No Yes
Please describe_____

EDUCATIONAL AND DEVELOPMENTAL INFORMATION

1. Do you have any problems of an academic nature? Yes No
If yes, describe issues: _____
_____

2. Please check the level of education you have completed:
□ HS Graduate □ GED □ Some College □ AA/2 yrs college □ BA/BS 4 yrs
□ Some Graduate School □ MA/2 yrs graduate □ Ph.D/4+ yrs graduate school □ Post-Graduate

3. Were you in special education classes? Yes No Unknown

4. Describe how you did in school. *Circle all that apply*:

Good/Decent Grades	Fair/Poor Grades	Retained
Learning Disability	No Behavior Issues	Some Behavior Issues
Frequent Behavior Issues	Suspended/Expelled	Dropped out

5. Do you have a history of any developmental delays or issues? Yes No
If yes, specify: _____
_____

6. Do you have qualities that could be academic strengths? Yes No
If yes, specify: _____
_____

VOCATIONAL INFORMATION

1. Current employment status. (*Circle*):

Active Military	Criminal Inmate	Disabled
Employed Full-Time	Employed Part-Time	Full-Time Student
Retired	Unemployed--Not Seeking	Unemployed--Seeking

2. How long at current job? _____ Days/Weeks/Months/Years

3. Do you have problems of a vocational nature? Yes No

4. Are you satisfied with your current job? Yes No

5. Have you experienced difficulty performing work or work-like activity? Yes No
If yes, *Circle all that apply*

On Disability	Applied for Disability	Difficulty Maintaining Jobs
No Work History	Difficulty with Social Work Interactions	Medical Problems Interfere

Describe the severity/frequency of work problems of any kind: _____
_____

Work History (List Current or Most Recent First):

Employer: Start/End Dates: Duties, Performance, Strengths/Problems:
_____

Financial Information

1. Source of income or support received during the last 12 months: *Circle all that apply*

Wages	Disability	Illegal Activity	Loans
None	Parents	Retirement	Social Security
Spouse/Significant Other	Children	Other:_____	

2. Do you currently have financial problems? Yes No
If yes, *Circle all that apply:*

Currently Unemployed	Numerous Medical Problems/Bills	Cannot Afford Medications
Difficulty Paying Bills	Difficulty Paying Utilities	Possible Homelessness
Owing/Paying Child Support	Legal/Probation Fees	Other

If yes, explain: _____

LEGAL HISTORY

1. Have you ever been arrested? Yes No

2. Do you have any present legal involvement: Yes No
   If yes, *Circle all that apply*:

Arrested, Not Convicted	Assault	Awaiting Sentence	Awaiting Trial
Convicted, Served Time	Currently in Jail	Currently in Prison	Deferred Adjudication
Deferred Prosecution	Drug/Alcohol Offense	On Bail	On Parole
On Probation	Sex Offender	Other:_____	

Explain:_____
_____

3. Do you have any past legal involvement: Yes No
If yes, *Circle all that apply*:

Arrested, Not Convicted	Assault	Awaiting Sentence	Awaiting Trial
Convicted, Served Time	Currently in Jail	Currently in Prison	Deferred Adjudication
Deferred Prosecution	Drug/Alcohol Offense	On Bail	On Parole
On Probation	Sex Offender	Other:_____	

Explain:_____
_____

STRENGTHS/WEAKNESSES/ BARRIERS TO TREATMENT

1. Describe any leisure activities or hobbies: *Circle all that apply*

Hunting/Fishing	Spending Time with Family	Playing on the Computer	Church Activities
Reading	Cooking	Working Outside	Shopping
Exercising	Home Improvement	Water Activities	Other

Comments:_____ _____
_____
_____

2. Who makes up your current support system? *Circle all that apply:*

Boy/Girlfriend	Spouse/Partner	Coworkers	Extended Family
Friends	Immediate Family	None	Religious Organization
Self-help Group	Social Service Group	Teachers	Other:_____

3. How do you cope with life events and daily stress? Please check all that apply

☐ Talk to family	☐ Talk to support group	☐ Other _____
☐ Talk to friends	☐ Resources on internet	☐ Other _____
☐ Pray	☐ Journal	☐ Other _____
☐ Talk with professional	☐ Yoga/Exercise	☐ Other _____

4. Please list your strengths: *Circle all that apply*:

Accurate	Dedicated	Humorous	Open minded	Social intelligence
Action oriented	Determined	Idealistic	Orderly	Social skills
Adventurous	Disciplined	Independent	Originality	Straightforward
Ambitious	Educated	Ingenuity	Organized	Strategic
Analytical	Empathetic	Industriousness	Outgoing	thinking
Appreciative	Energetic	Inner peace	Patient	Tactful
Artistic	Entertaining	Inspiring	People skills	Team oriented
Athletic	Enthusiastic	Integrity	Perseverance	Thoughtful
Authentic	Fairness	Intelligent	Persuasive	Thrifty
Bravery	Fast	Kindness	Persistent	Tolerant
Caring	Flexible	Knowledgeable	Practical	Trustworthy
Citizenship	Focused	Leadership	Precise	Versatile
Clever	Forceful	Lively	Problem solving	Visionary
Compassionate	Forgiveness	Logical	Prudence	Vitality
Charming	Friendly	Love	Respectful	Warm
Communicative	Generous	Love of learning	Responsible	Willpower
Confident	Good looking	Mercy	Self assured	Wisdom
Considerate	Gratitude	Modesty	Serious	Other:_____
Courageous	Hope	Motivated	Self controlled	
Creativity	Humility	Observant	Speaking	Other:_____
Critical thinking	Helping	Optimistic	Spirituality	
Curiosity	Honest	Open	Spontaneous	Other:_____
				Other:_____

5. Are there any **barriers or challenges** to treatment and to change? Yes No
   If yes, *circle all that apply*

Anger	Aggression	Childcare	Cultural Beliefs
Family Members	High Anxiety	Unstable Living Conditions	Medical Complications
Memory Impairment	Pregnancy	Past Treatment Experience	Religious Beliefs
Severe Depression	Substance Use	Medication Side Effects	Transportation
Work Schedule	Other: _____		

   Explain: _____
   _____

Please check which Stage of Change best describes you at this time

- ☐ **Stage #1: Pre-Contemplation**

The Client may be aware of the costs of his/her dysfunctional behavior, however, he/she does not see them as significant as compared to the benefits. Of course, others may view this situation differently. The Client shows characteristics of interest in change, but has no plan or intention to change. The Client could be described as unaware.

- ☐ **Stage#2: Contemplation**

The Client has become aware of problems associated with his/her behavior, however, he/she is ambivalent about whether or not it is worthwhile to change. The Client is exploring the potential to change; desiring change but lacking the confidence and commitment to change behavior; and having the intention to change at some unspecified time in the future. The Client can be described as aware and open to change.

- ☐ **Stage #3: Preparation**

The client has made a decision to change and has concluded that the negatives of their behavior outweigh the positives. This decision represents an event, not a process.

The client accepts responsibility to change his/her behavior. He/ She has evaluated and selected techniques for behavioral change. Characteristics of this stage include: developing a plan to make the needed changes; building confidence and commitment to change; and having the intention to change within one month. The Client can be described as willing to change and anticipating of the benefits of change.

- ☐ **Stage #4: Action**

The Client is engaging in self-directed behavioral change efforts while gaining new insights and developing new skills. The Client is consciously choosing new behavior; learning to overcome the tendencies toward unwanted behavior; and engaging in change actions for less than six months. The Client is described as enthusiastically embracing change and gaining momentum.

- ☐ **Stage #5: Maintenance**

The Client has mastered the ability to sustain new behavior with minimal effort. He/ She has established new behavioral patterns. The Client is remaining alert to high-risk situations; maintaining a focus on relapse

prevention; and behavioral change that has been sustained approximately six months. The Client can be described as persevering and consolidating their change efforts. He/ She is integrating change into the way they live their life.

- **Stage #6: Termination**

The Client has adopted a new self-image consistent with desired behavior and lifestyle. The Client does not react to triggers/temptations in any situation. The client is confidence; enjoying self-control; and appreciation of a healthier and happier life. The relapse prevention plan has evolved into the pursuit of a meaningful and healthy lifestyle. As such, relapse into the former way of life becomes almost unthinkable.

I have answered truthfully and to the best of my ability regarding all of the information contained in this Adult Intake Assessment.

Initial Goals for Treatment:

1. _____

2. _____

3. _____

Patient Signature_____ Date _____

Therapist Signature _____ Date _____

Client Name_____

Crisis and Safety Plan for _____

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____ 2. _____

3. _____ 4. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity): See Coping Technique Handout

1. _____ 2. _____

3. _____ 4. _____

Step 3: People whom I can ask for help and social settings that provide distraction:

1. Name_____ Phone_____

2. Name_____ Phone_____

3. Place_____

4. Place_____

Step 4: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____

2. Clinician Name_____ Phone_____

3. Arrow Counseling After Hour Emergency phone number: (717) 758-8075

4. Crisis Intervention Services Phone number: 717-851-5320

5. Hospital Address: **York Hospital, 1001 S. George St, York Pa 17401; Memorial Hospital, 325 S. Belmont St, York, PA 17405: Hanover Hospital , 300 Highland Ave, Hanover, PA 17331**

6. Emergency Services: **Dial 911 on phone**

Step 5: Making the environment safe:

1.
_____

2.
_____

Step 6: Medications I can take during a crisis (Take as prescribed by medical doctor)

Name	Dosage	Frequency	Prescribed By

I will not hurt myself or anyone else, but rather will abide by this plan and seek help during a crisis.

Patient Signature_____ Date _____

Therapist Signature _____ Date _____

Client Name_____

Mental Status Exam (For Clinician Use Only) Patient _____

Appearance
- ☐ Well Groomed
- ☐ Disheveled
- ☐ Bizarre
- ☐ Body Odor

Mood
- ☐ Normal
- ☐ Depressed
- ☐ Anxious
- ☐ Euphoric
- ☐ Irritable

Attitude
- ☐ Cooperative
- ☐ Uncooperative
- ☐ Suspicious
- ☐ Guarded
- ☐ Belligerent/Hostile

Motor Activity
- ☐ Calm
- ☐ Hyperactive
- ☐ Agitated
- ☐ Tremor/Tics
- ☐ Lethargic

Affect
- ☐ Appropriate
- ☐ Sad
- ☐ Flat
- ☐ Anxious
- ☐ Inappropriate
- ☐ Angry
- ☐ Constricted
- ☐ Labile

Thought Content
- ☐ Normal
- ☐ Morbid
- ☐ Somatic complaints
- ☐ Aggressive
- ☐ Paranoid
- ☐ Phobias
- ☐ Obsessive
- ☐

Hallucinations
- ☐ Auditory
- ☐ Visual
- ☐ Denies

Delusional Beliefs
- ☐ Religious
- ☐ Somatic
- ☐ Persecutory
- ☐ Grandiosity
- ☐ Being controlled
- ☐ Ideas of reference
- ☐ Denies

Bizarre Delusions
- ☐ Thought Broadcasting
- ☐ Thought Insertion
- ☐ Thought Withdrawal
- ☐ Denies

Orientation
- ☐ Person
- ☐ Place
- ☐ Time
- ☐ Responds to name
- ☐ Knows familiar faces or places
- ☐ Knows own daily schedule

Thought Process
- ☐ Intact
- ☐ Tangential
- ☐ Circumstantial
- ☐ Loose Associations
- ☐ Flight of ideas
- ☐ concrete thinking
- ☐ Inability to abstract
- ☐ Follow 1-step directions

Speech
- ☐ Normal
- ☐ Soft
- ☐ Loud
- ☐ Pressured
- ☐ Halting
- ☐ Incoherent
- ☐ Slurred
- ☐ Nonverbal
- ☐ Limited communication skills
- ☐ Uses yes/no only
- ☐ Uses a picture board

Insight
- ☐ Good
- ☐ Fair
- ☐ Poor

Judgment
- ☐ Intact
- ☐ Impaired

Command Hallucinations
- ☐ Harm to self
- ☐ Harm to others
- ☐ Can resist commands
- ☐ Denies

_____ _____

Therapist Signature Date