



Lake Country Associates ~ Initial Intake

Name of Client: _____ Former or Maiden Name: _____

Date of Birth: _____ Age: _____ SSN# _____ Gender: Male Female

Mail Address: _____ Physical Address: _____

City: _____ State: _____ Zip: _____ County _____ Referral source: _____

Indicate best way to reach you Home #: _____ Cell# _____ Text OK Yes No

Do you have difficulty with reading or writing? Yes No Name of person completing form: _____

Employment: Full-time Part-time Student Retired Unemployed Disabled

Employer: _____ Work # _____ Occupation: _____

Marital Status: Married Widowed Divorced Separated Never married

Education: 1 2 3 4 5 6 7 8 9 10 11 12 Diploma GED College/Vocational 1 2 3 4 5 6 Degree _____

Race: White Black/African American Native American/Alaskan Tribe: _____
 Asian Native Hawaiian/Pacific Islander Hispanic/Latino

Client Lives: Alone With immediate family With extended family With non-related

Client lives in: Private Residence (home/apartment) Shelter/Homeless Other Residential Setting
 Correctional Facility Other institution setting Other _____

Are you a Veteran? Yes No If Yes, date of discharge _____

Is the reason you are wishing to be seen at LCA military related? Yes No

Have you had a diagnostic assessment completed within the past year at another mental health agency? Yes No

If yes, please tell us the name of the agency _____

Does a copy of your assessment need to be forwarded to someone outside of this office? Yes No If yes, please tell us
Who _____ Office _____

People living in the same household:

Name Age Relationship M/F Employer Phone

Name Age Relationship M/F Employer Phone

Name Age Relationship M/F Employer Phone

Name Age Relationship M/F Employer Phone

Name Age Relationship M/F Employer Phone

In case of emergency, who may we contact?

Name Relationship to You Phone Number

"I authorize Lake Country Associates, Inc. to release necessary information to my emergency contact in the event of an emergency. "Initial _____

Client Initial: _____ Chart #: _____ DOB: _____ Today's Date: _____

WHODAS 2.0

Name: _____ Chart#: _____ Date: _____

This questionnaire asks about difficulties due to health conditions. Health conditions include disease or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the **past 30 days** and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

In the past 30 days, how much difficulty did you have in:		None	Mild	Moderate	Severe	Extreme or Cannot Do
S1	Standing for long periods such as 30 minutes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S2	Taking care of your household responsibilities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S3	Learning a new task such as how to get a new place?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S4	How much of a problem did you have joining in community activities (festivities, religious or other activities) in the same way as anyone else?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S5	How much have you been emotionally affected by your health problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S6	Concentrating on doing something for 10 minutes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S7	Walking a long distance such as a half mile?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S8	Washing your whole body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S9	Getting dressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S10	Dealing with people you do not know?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S11	Maintaining a friendship?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S12	Your day-to-day work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total number of Xs in each column _____

H1 Overall in the past 30 days, how many days were these difficulties present **# of DAYS** _____

H2 In the past 30 days, how many days were you totally unable to carry out your usual activities or work because of any health condition? **# of DAYS** _____

H3 In the past 30 days, not counting the days that you were totally unable, how many days did you cut back or reduce your usual activities or work because of any health condition? **# of DAYS** _____

Client Initial: _____ Chart #: _____ DOB: _____ Today's Date: _____

PHQ - 9 Depression Assessment

Over the past 2 weeks, how often have you been bothered by any of the following problems?
 Circle the number under the correct answer heading for each question.

	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 or 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 are a failure or have let yourself or family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching TV	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. Thought that you would be better off dead or hurting yourself in some way	0	1	2	3
Total Score of each column	_____	_____	_____	_____

If you checked any problems, how difficult have these 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

<u>PHQ-9 Score</u>	Depression Severity	Total of all columns _____
1 to 4	None	
5 to 9	Mild	
10 to 14	Moderate	
15 to 19	Moderately Severe	
20 to 27	Severe	

The Generalized Anxiety Disorder 7-Item Scale

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score: = Add Columns _____ + _____ + _____ + _____

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

- Not at all
 Somewhat difficult
 Very difficult
 Extremely Difficult

Interpreting the Score:

Total Score	Interpretation
≥10	Possible diagnosis of GAD; confirm by further evaluation
5	Mild Anxiety
10	Moderate anxiety
15	Severe anxiety

CAGEAID

Alcohol: Age at first time used _____ Age at first used to intoxication _____
 Last used _____ Last used to intoxication _____
 What? How often? How much? _____

Marijuana: Age at first time used _____ Age at first used to intoxication _____
 Last used _____ Last used to intoxication _____
 How often? How much? _____

Other drugs Age at first time used _____ Age at first used to intoxication _____
 or abuse of Last used _____ Last used to intoxication _____
 prescriptions: What? How often? How much? _____

CAGEAID

- 1. Have you ever felt you ought to cut down on your drinking or drug use? YES NO
- 2. Have you ever had people annoy you by criticizing your drinking or drug use? YES NO
- 3. Have you ever felt bad or guilty about your drinking or drug use? YES NO
- 4. Have you ever had a drink or used drugs as an eye-opener first thing in the morning to steady your nerves or get rid of a hangover or to get the day started? YES NO
- 5. Have there been negative events which occurred during alcohol or drug use? YES NO

If so, what _____

Do you use tobacco products? YES NO

What? How often? How much? _____

Do you drink caffeinated beverages? YES NO

What? How often? How much? _____

Order for protection and restraining order policy (Please read and sign):

In order to ensure the safety of our clients and clinicians, it is mandatory that we be informed and provided copies of any current or future Orders for Protection and/or Restraining Orders concerning our clients. We are further bound to comply with existing OFP's and Restraining Orders. I understand and will comply with the LCA policy concerning disclosure of restraining orders.

Signature of client (or client's guardian)

Date

Is there currently an Order for Protection (OFP) or Harassment Order in place from any state regarding a member of your household?

Yes No If yes, name of family member _____

Name of other party involved _____

Expiration Date of Order _____

CHECKLIST OF CONCERNS

Describe what changes in your life you are seeking by coming to LCA:

Please mark all of the items below that apply to you. Circle the one that is most important.

- | | |
|---|--|
| <input type="checkbox"/> Marital/family problems | <input type="checkbox"/> Abuse/assault victim |
| <input type="checkbox"/> Social/interpersonal (not family) problems | <input type="checkbox"/> Sexual abuse/rape victim |
| <input type="checkbox"/> Coping with daily roles | <input type="checkbox"/> Child behavior problems |
| <input type="checkbox"/> Medical/physical symptoms | <input type="checkbox"/> Major mental illness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Psychiatric medication |
| <input type="checkbox"/> Attempt, threat, danger of suicide | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Alcohol/drugs | <input type="checkbox"/> Perpetrator of sexual abuse |
| <input type="checkbox"/> Court evaluation referral | <input type="checkbox"/> Anger management |
| <input type="checkbox"/> Program entrance evaluation | <input type="checkbox"/> Gambling |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Codependency issues |
| | <input type="checkbox"/> ADD/ADHD |

Please continue checking all items that apply to you:

- | | |
|---|---|
| <input type="checkbox"/> Aggression, violence | <input type="checkbox"/> Headaches, other kinds of pain |
| <input type="checkbox"/> Career concerns, goals and choices | <input type="checkbox"/> Inferior feelings |
| <input type="checkbox"/> Childhood issues (your own childhood) | <input type="checkbox"/> Impulsiveness, loss of control, outbursts |
| <input type="checkbox"/> Children, child management, child care, parenting | <input type="checkbox"/> Irresponsibility |
| <input type="checkbox"/> Concentration | <input type="checkbox"/> Judgment problems, risk taking |
| <input type="checkbox"/> Compulsions (actions that are repeated) | <input type="checkbox"/> Legal matters, charges, suits |
| <input type="checkbox"/> Custody of children | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Decision making, indecision, putting off decisions | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Delusions (false ideas) | <input type="checkbox"/> Menstrual problems, PMS, menopause |
| <input type="checkbox"/> Dependence | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Emptiness | <input type="checkbox"/> Motivation, laziness |
| <input type="checkbox"/> Failure | <input type="checkbox"/> Nervousness, tension |
| <input type="checkbox"/> Fatigue, tiredness, low energy | <input type="checkbox"/> Obsessions (thoughts that are repeated) |
| <input type="checkbox"/> Fears, phobias | <input type="checkbox"/> Overly sensitive to rejection |
| <input type="checkbox"/> Financial or money worries | <input type="checkbox"/> Panic or anxiety attacks |
| <input type="checkbox"/> Work problems, workaholic, can't keep a job | <input type="checkbox"/> Perfectionism |
| <input type="checkbox"/> Grieving, mourning, deaths, losses, divorce | <input type="checkbox"/> Pessimism |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Procrastination, work inhibitions |
| <input type="checkbox"/> Relationship problems | <input type="checkbox"/> School problems |
| <input type="checkbox"/> Self-centeredness | <input type="checkbox"/> Self-esteem |
| <input type="checkbox"/> Self-neglect, poor self-care | <input type="checkbox"/> Sexual issues (dysfunction, conflicts, desire differences) |
| <input type="checkbox"/> Shyness, over sensitivity to criticism | <input type="checkbox"/> Sleep problem (too much, too little, insomnia, nightmares) |
| <input type="checkbox"/> Smoking and tobacco use | <input type="checkbox"/> Suspiciousness |
| <input type="checkbox"/> Thought disorganization and/or confusion | <input type="checkbox"/> Threats, violence |
| <input type="checkbox"/> Weight and diet issues | <input type="checkbox"/> Withdrawal, isolating |
| <input type="checkbox"/> Recreation/hobbies | <input type="checkbox"/> Other concerns or issues _____ |

Lake Country Associates

Medical Information Supplement page 1

In order to provide high quality care, please complete the following. This information will become part of the Diagnostic Assessment.

Are you allergic to any drugs? Yes No

If Yes, please list _____

Do you have any other allergies? Yes No

For example, foods, air borne, etc. If Yes, please list _____

Are you pregnant? Yes No

Who is your medical doctor? _____

Name of Clinic and location _____

When was your last physical examination? _____ Results: _____

Have you experienced a recent weight loss or weight gain? Yes No

Do you have any problems that might interfere with your receiving service at Lake Country Associates? Yes No

If Yes, please list _____

Have you received services for alcohol and/or drug problems in the past? Yes No

If Yes, where? _____

Have you ever been treated for any of the following?

- | | |
|--|---|
| <input type="checkbox"/> Birth or developmental problems in childhood | <input type="checkbox"/> Chronic illness |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Alcohol issue | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High blood pressure (hypertension) |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Chest pain, palpitations |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Lung disease, pneumonia |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Serious injury or accident |
| <input type="checkbox"/> Head injury (epilepsy, seizures, convulsions, confusion) | <input type="checkbox"/> Sexual performance problems |
| <input type="checkbox"/> Headaches, migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Low energy | <input type="checkbox"/> Problems with appetite |
| <input type="checkbox"/> Skin problems | <input type="checkbox"/> Gastrointestinal problems |
| <input type="checkbox"/> Past surgeries | <input type="checkbox"/> Ongoing pain or discomfort |
| <input type="checkbox"/> Gastric bypass | <input type="checkbox"/> Other _____ |

If any of the above boxes are checked, please comment on length and duration of problem _____

Lake Country Associates

Medical Information Supplement page 2

Have you had any past suicide thoughts or attempts? Yes No

If so, please list _____

When _____

Have you had any visits to the Emergency Room in the last year? Yes No

If Yes ,what symptoms were you experiencing when you went to the ER? _____

Have you had any hospitalizations related to mental health? Yes No

If Yes, when _____

Where _____

What symptoms were you experiencing when you were hospitalized? _____

Are you currently or have you been treated for any mental health conditions? Yes No

If Yes, when _____

Where _____

Are you currently taking any medications? Yes No

If Yes, please list below

<u>Medication Name</u>	<u>Dosage</u>	<u>How often</u>	<u>Prescribed by</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Medications _____

Do you take vitamins, herbal medications, diet supplements or over-the counter medications? Yes No

If yes, what type, how much and for how long? _____

Have you taken more of a prescription medication than recommended by your doctor? Yes No

If yes, what type, how much and for how long? _____

Do you have a Health Care Directive? Yes No

If yes, where do you keep it? _____

If no, would you like information on one? Yes No If yes, was information given to client? Yes No