LAKE COUNTRY ASSOCIATES, INC.

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11 Main Street East Menahga, MN 56164 ph: 218-564-9229
Fax: 218-237-2520

Date: ____________

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 the 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: ______________________ 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 ☐ Asian ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ Alaskan/Native American Tribe: ____________

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 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 emergency* Initial: ________

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 over eating	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 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 someway	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

PHQ-9 Score	Depression Severity
1 to 4	None
5 to 9	Mild
10 to 14	Moderate
15 to 19	Moderately Severe
20 to 27	Severe

Total of all Columns: _________

Client Initial: ________________ DOB: ______________ Today's Date: _______________

The Generalized Anxiety Disorder 7-Item Scale

Over the last 2 weeks, 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 Difficult 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

Client Initial: _______________ DOB: _____________ Today's Date: ______________

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: __________

What? How often? How much? ____

____

Other drugs Or abuse of Prescriptions: Age at first time used: __________ Age at first used to intoxication: __________

Last Used: __________ Last used to intoxication: __________

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 of 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 the most important.

☐ Marital/family Problems
☐ Social/interpersonal (not family) problems
☐ Coping with daily roles
☐ Medical Physical symptoms
☐ Depression
☐ Attempt, threat, danger of suicide
☐ Alcohol/drugs
☐ Court Evaluation Referral
☐ Program entrance Evaluation
☐ Eating disorder
☐ Anxiety
☐ Abuse/assault victim
☐ Sexual abuse/rape victim
☐ Child behavior problems
☐ Major mental illness
☐ Psychiatric medication
☐ Other: ____
☐ Perpetrator of sexual abuse
☐ Anger Management
☐ Gambling
☐ Stress
☐ ADD/ADHD

Please continue checking all items that apply to you:

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

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 services 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?

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

If any of the boxes are checks, please comment on length and duration of problem: ______________________________

____

____

____

Client Initial: ______________ DOB: ______________ Today's Date: ______________

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 were 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:

Medication Name	Dosage	How often	Prescribed by

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 that recommended by your doctor? ☐ Yes ☐ No

If yes, 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 the information given to the client? ☐ Yes ☐ No

Client Initial: ____________ DOB: ____________ Today's Date: ____________