COMMUNITY PARTNERSHIP
Care Coordination

Behavioral Health Assessment

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

❑ White ❑ Black/African-American ❑ Native Hawaiian/Pacific Islander ❑ Asian ❑ Hispanic/Latino
❑ American Indian/Alaska Native - Tribe: _____ ❑ Multiracial ❑ Not Hispanic/Latino

Date of Birth ___/___/_____ Age _____ Legal Gender: ❑ Female ❑ Male Gender: ❑ Female ❑ Male ❑ Trans Man ❑ Trans Woman

PERSONAL AND FAMILY INFORMATION

Describe any current or past involvement with the legal system. (For example, parole, probation, incarceration, DUI conviction, etc.)

Currently a student? ❑ No ❑ Yes
Currently employed? ❑ No ❑ Yes
Name of school/employer _____ Highest grade completed _____

Serve(d) in the Military? ❑ No ❑ Yes, years of service: _____
Child or Spouse of a Military Service Member? ❑ No ❑ Yes, child ❑ Yes, spouse

Any cultural, religious, and/or spiritual beliefs that provide comfort during difficult times?
❑ No ❑ Yes, please describe: _____

❑ Single ❑ Married ❑ Widowed ❑ Not married, but living with partner

Tell us about the patient's family

Name	Relationship to Patient	Age	Deceased	Lives with Patient
			❑ No ❑ Yes	❑ No ❑ Yes
			❑ No ❑ Yes	❑ No ❑ Yes
			❑ No ❑ Yes	❑ No ❑ Yes
			❑ No ❑ Yes	❑ No ❑ Yes
			❑ No ❑ Yes	❑ No ❑ Yes
			❑ No ❑ Yes	❑ No ❑ Yes
			❑ No ❑ Yes	❑ No ❑ Yes
			❑ No ❑ Yes	❑ No ❑ Yes
			❑ No ❑ Yes	❑ No ❑ Yes

Who else lives with the patient in their home?

Name	Relationship to Patient	Age

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MEDICAL AND BEHAVIORAL HEALTH INFORMATION

How does the patient rate their physical health?

Poor	Fair	Good	Very good	Excellent
1	2	3	4	5

How does the patient rate their mental health?

Poor	Fair	Good	Very good	Excellent
1	2	3	4	5

Currently pregnant?
❑ No ❑ Yes ❑ N/A

Currently chew or smoke tobacco?
❑ No ❑ Yes

Recent significant weight loss or gain?
❑ No ❑ Yes

On average, how many hours of sleep per night? _____

On average, how many minutes of exercise per day? _____

Binge food?
❑ No ❑ Yes

Binge and purge food?
❑ No ❑ Yes

Limit or restrict food consumption?
❑ No ❑ Yes

Concerns with gender identity?
❑ No ❑ Yes

Concerns with sexual orientation?
❑ No ❑ Yes

Concerns with sexual function?
❑ No ❑ Yes

Patient diagnosed with psychiatric illness(es)?
❑ No ❑ Yes

Any family diagnosed with psychiatric illness(es)?
❑ No ❑ Yes

Patient with substance abuse issues?
❑ No ❑ Yes

Any family with substance abuse issues?
❑ No ❑ Yes

Patient attempted suicide in the past?
❑ No ❑ Yes

Any family attempted or completed suicide in the past?
❑ No ❑ Yes

Patient psychiatrically hospitalized in the past?
❑ No ❑ Yes

Any family psychiatrically hospitalized in the past?
❑ No ❑ Yes

CURRENT MEDICAL AND BEHAVIORAL HEALTH PROVIDERS

Primary Care Provider	Phone Number	Date last seen / /
Psychiatrist / Psychiatric Nurse Practitioner	Phone Number	Date last seen / /
Therapist / Counselor	Phone Number	Date last seen / /
Other: _____	Phone Number	Date last seen / /

ALLERGIES

Allergies (drugs, food, latex, etc.)	What symptoms do you experience?

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MEDICATIONS AND COMMON CONDITIONS

Current Medications (include prescribed and over-the-counter, including vitamins and supplements)	Dosage	How often do you take that dose?	Take for what condition?

Has the patient or a close relative (parent, sibling, child, or grandparent) been diagnosed with the following?

	Patient	Family
Heart attack, angina	❑ No ❑ Yes	❑ No ❑ Yes, which relative? _____
Stroke	❑ No ❑ Yes	❑ No ❑ Yes, which relative? _____
High blood pressure	❑ No ❑ Yes	❑ No ❑ Yes, which relative? _____
High cholesterol	❑ No ❑ Yes	❑ No ❑ Yes, which relative? _____
Diabetes	❑ No ❑ Yes	❑ No ❑ Yes, which relative? _____
Thyroid disease	❑ No ❑ Yes	❑ No ❑ Yes, which relative? _____
Breast cancer	❑ No ❑ Yes	❑ No ❑ Yes, which relative? _____
Colorectal cancer	❑ No ❑ Yes	❑ No ❑ Yes, which relative? _____
Kidney disease	❑ No ❑ Yes	❑ No ❑ Yes, which relative? _____
Osteoporosis	❑ No ❑ Yes	❑ No ❑ Yes, which relative? _____
Rheumatoid arthritis	❑ No ❑ Yes	❑ No ❑ Yes, which relative? _____
Asthma	❑ No ❑ Yes	❑ No ❑ Yes, which relative? _____

Has the patient been a victim of trauma or abuse (including sexual, emotional, physical abuse or neglect and/or being a victim of an accident, violent crime, or natural disaster)?

❑ No ❑ Yes

Name of person completing this form	Signature	Date
		/ /

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Behavioral Health Assessment

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Presenting issue

Symptoms reported, duration, onset

Assessment conclusions

Psychotherapy/counseling appropriate and recommended? ❑ No ❑ Yes

Psychiatric care appropriate and recommended? ❑ No ❑ Yes

Referral to other behavioral health provider appropriate and recommended? ❑ No ❑ Yes

Referral to primary care provider appropriate and recommended? ❑ No ❑ Yes

Referral to other specialist appropriate and recommended? ❑ No ❑ Yes

Name of staff completing this form

Credentials of staff completing this form

Signature of staff

/ /

Date

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Care Coordination

Name: _____ DOB: _____
Date: _____

AUDIT

Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on once occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

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Date: AUDIT Total Score: Clinician:

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Name: _____ DOB: _____
Date: _____

DAST-10

Below is a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words “drug abuse” are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in this section.

	No	Yes
1. Have you used drugs other than those required for medical reasons?	0	1
2. Do you use more than one drug at a time?	0	1
3. Are you always able to stop using drugs when you want to?	0	1
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you ever feel bad or guilty about your drug use?	0	1
6. Does your spouse (or parents) ever complain about your involvement with drugs?	0	1
7. Have you neglected your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	0	1

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Date: DAST-10 Total Score: Clinician:

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Name: _____ DOB: _____
Date: _____

GAD-7

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

If you circled 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

PHQ-9

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading thenewspaper or watching television	0	1	2	3
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
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

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

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Date: GAD-7 Total Score: PHQ-9 Score: Clinician: